Agenda Item

1

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board Audit Committee - 28 June 2016 Integration Joint Board - 28 June 2016
Report Title:	2015-16 Unaudited Annual Accounts
Reference Number:	CC-47-17 F
Author / Job Title:	Karl Williamson / IJB Chief Financial Officer

Decisions / Action required:

The IJB Audit Committee is asked to:

1 Consider the unaudited Annual Accounts for 2015/16;
2 Note the timetable for submission of the Annual Accounts to the Controller of Audit;
3 Otherwise note the contents of the report.

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2 Note the timetable for submission of the Annual Accounts to the Controller of Audit;
3 Otherwise note the contents of the report.

High Level Summary:

1 The purpose of this report is to advise the IJB of requirements introduced by the Local Authority Accounts (Scotland) Regulations 2014, to submit the Annual Accounts for the year ended 31 March 2016 to the IJB for approval and thereafter to forward them to the Controller of Audit.

2 The 2014 Regulations require IJB Members to consider the unaudited accounts at a meeting to be held no later than 31 August. In addition, the IJB, or a committee whose remit includes audit or governance functions, must consider the audited accounts and aim to approve the Annual Accounts for signature no later than 30 September with publication no later than 31 October. Consequently, the 2015/16 unaudited Annual Accounts will be presented to the IJB Audit Committee and IJB on 28 June 2016. The External Auditors ISA 260 Report, which will detail the outcome of the audit of the annual accounts, will also be presented to the IJB meeting on 23 September.

3 The outturn for the financial year 2015/16 is a break even position for the IJB. The total cost of services was £16.320m.

Corporate Priorities and Strategic Aims:
Aids in the assessment of the IJB's ability to provide best value for resources and deliver financial balance as outlined in the Strategic Commissioning Plan.
Key Issues:
The Accounts include the part year contributions from the Parties, representing 19 weeks of the annual agreed budgets. Similarly, part year payments to the Parties from the IJB for carrying out its directions have been made based on the 19 week period from the integration start date to 31 March 2016. The IJB is presenting a breakeven position in 2015/16 even though there were significant variances in both arms of the operational budget. This is due to the fact that the under spend in the Shetland Island Council (SIC) arm of the budget £688k was fortuitous and was therefore returned to the SIC as per the Integration Scheme. Likewise the over spend in the NHS Shetland (NHSS) arm of the budget £367 had to be funded by additional contributions from NHSS.

Implications :	
Service Users, Patients and Communities:	None
Human Resources and Organisational Development:	Considerable efforts have been made to address recruitment and retention issues particularly within social care and the positive effects have been reported to IJB in quarter four, 2015/16, where there was a marked reduction in overtime hours for social care.
Equality, Diversity and Human Rights:	None
Partnership Working	The core nature of the IJB represents joint working between Shetland Islands Council and NHS Shetland.
Legal:	The Local Authority Accounts (Scotland) Regulations 2014 require IJB Members to consider the unaudited accounts at a meeting to be held no later than 31 August.
Finance:	This forms part of the annual performance cycle which along with other information aids members in establishing their view on whether the objectives of the Strategic Commissioning Plan have been achieved.
Assets and Property:	None
Environmental:	None
Risk Management:	None

Policy and Delegated Authority:	The IJB has terms of reference to approve the draft and final annual financial accounts of the IJB and any related matters.
Previously considered by:	The Governance Statement was previously considered by the IJB Audit Committee on 27th May 2016

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	28 June 2016
Report Title:	Draft 2015/16 Annual Accounts
Reference Number:	CC-47-16 F
Author / Job Title:	Karl Williamson / Chief Financial Officer

1. Introduction

1.1 The purpose of this report is to advise the IJB of requirements introduced by the Local Authority Accounts (Scotland) Regulations 2014, to submit the Annual Accounts for the year ended 31 March 2016 to the IJB for consideration and thereafter to forward them to the Controller of Audit.

2. Background

2.1 IJBs are specified in legislation as 'Section 106' bodies under the terms of the Local Government (Scotland) Act 1973. Consequently IJBs are expected to prepare their financial statements in compliance with the Code of Practice on Local Government Accounting in the United Kingdom. The Scottish Government issued Finance Circular 7/2014 in May 2014 advising on the requirements of the Local Authority Accounts (Scotland) Regulations 2014 which apply to the statutory Annual Accounts commencing with the financial year 2014/15. The new regulations revoke The Local Authority Accounts (Scotland) Regulations 1985.

2.2 The Integrated Resource Advisory Group (IRAG) has issued guidance on financial aspects of the integration process. This includes an initial example of accounts for an IJB. The Local Authority (Scotland) Accounts Advisory Committee (LASAAC) issued Additional Guidance for the Integration of Health and Social Care 2015/16. This guidance has been developed to support consistency of treatment and the appropriate implementation of financial reporting for integration.

2.3 The 2014 Regulations require IJB Members to consider the unaudited accounts at a meeting to be held no later than 31 August. In addition, the IJB, or a committee whose remit includes audit or governance functions, must consider the audited accounts and aim to approve the Annual Accounts for signature no later than 30 September with publication no later than 31

October. Consequently, the 2015/16 unaudited Annual Accounts will be presented to the IJB Audit Committee and IJB on 28th June 2016.

2.4 The Regulations also require the IJB to meet by 30 September to approve the audited annual accounts for signature. Immediately after approval, the annual accounts require to be signed and dated by specified members and officers and then provided to the external auditors. The Controller of Audit requires audit completion and issue of an independent auditor's report (opinion) by 30 September each year. The audited annual accounts will be presented to the IJB on 23 September along with the External Auditors ISA 260 Report, which will detail the outcome of the audit of the annual accounts.

3. Detail

3.1 The Strategic Commissioning Plan 2015/16 sets out the functions which have been delegated by the Parties and the associated agreed budgets. The Plan was agreed by IJB Members on 20 November 2015. As defined in the Public Bodies (Joint Working) (Scotland) Act 2014, Section 29 (6), this is considered the "integration start day".

3.2 The Accounts include the part year contributions from the Parties, representing 19 weeks of the annual agreed budgets. Similarly, part year payments to the Parties from the IJB for carrying out its directions have been made based on the 19 week period from the integration start date to 31 March 2016.

3.3 Running costs for the IJB have been included from the establishment date.

3.4 The purpose of the Annual Accounts is to present a public statement on the stewardship of funds for the benefit of both Members of the IJB and the public. The IJB is funded by Shetland Islands Council (SIC) and Shetland Health Board (NHSS).

3.5 The Statement of Income and Expenditure presents the full economic cost of providing the Board's services in 2015/16 from the date of establishment to 31 March 2016.

3.6 The IJB is presenting a breakeven position in 2015/16 even though there were significant variances in both arms of the operational budget. This is due to the fact that the under spend in the SIC arm of the budget was fortuitous and was therefore returned to the SIC as per the Integration Scheme. Likewise the over spend in the NHSS arm of the budget had to be funded by additional contributions from the NHSS.

3.7 The Integration Scheme states that where there is a planned, forecast, under spend on an element of the operational budget due to agreed changes in line with the Strategic Plan, this will be retained by the IJB to either fund other service areas in-year in line with the Strategic Plan or be carried forward to fund services in subsequent years of the Strategic Plan. However, any windfall under spend will be returned to the Council and/or the Health Board in line with the original budget allocation for 2015/16.

3.8 Where there is a forecast over spend against an element of the operational budget, the Chief Officer and the Chief Financial Officer of the Integration Joint Board will work with the Local Partnership Finance Team and the appropriate finance officers of the Parties to agree a recovery plan to balance the overspending budget. The recovery plan shall be subject to the approval of the IJB.

The table below details the variances and additional transactions required:

	SIC £'000	NHSS £'000	Total £'000
1 Budgets delegated to the Parties from the IJB	(7,747)	(8,554)	(16,301)
2 Contribution from the Parties to the IJB (against delegated budgets)	7,059	8,921	15,980
3 Variance	(688)	367	(321)
4 Additional contributions from Parties to meet IJB Direct Costs	9	10	19
5 IJB Direct Costs (Audit fee, Insurance & Members Expenses)	(9)	(10)	(19)
6 Fortuitous underspend repaid to SIC	688	-	688
6 Additional contribution from NHS to IJB to meet overspend	-	(367)	(367)
7 Final balanced position of IJB	-	-	-

3.9 The table below details the full year financial position for the IJB and is broken down by service area. Although the accounts are apportioned to represent the period from 20 November 2015(the date the functions were delegated) to 31 March 2016, the full year analysis provides a more meaningful summary.

Service Heading	ANNUAL BUDGET				OUTTURN				OUTTURN VARIANCE			
	JOINT BUDGETS		SET ASIDE		JOINT BUDGETS		SET ASIDE		JOINT BUDGETS		SET ASIDE	
	NHS	SIC	BUDGET	TOTAL	NHS	SIC	BUDGET	TOTAL	NHS	SIC	BUDGET	TOTAL
	£	£	£	£	£	£	£	£	£	£	£	£
Mental Health	1,318,107	1,347,701	0	2,665,808	1,298,925	1,091,149	0	2,390,074	19,182	256,553	0	275,735
Substance Misuse	570,117	254,519	0	824,636	562,731	209,310	0	772,041	7,386	45,209	0	52,595
Oral Health	3,253,206	0	0	3,253,206	3,281,661	0	0	3,281,661	-28,455	0	0	-28,455
Pharmacy & Prescribing	4,916,057	0	1,121,864	6,037,921	5,173,668	0	1,062,790	6,236,458	-257,611	0	59,074	-198,537
Primary Care	4,563,657	0	0	4,563,657	4,904,407	0	0	4,904,407	-340,750	0	0	-340,750
Community Nursing	2,387,175	0	0	2,387,175	2,355,228	0	0	2,355,228	31,947	0	0	31,947
Directorate	-238,276	561,381	0	323,105	169,786	349,975	0	519,761	-408,062	211,406	0	-196,656
Pensioners	0	0	0	0	0	0	0	0	0	0	0	0
Sexual Health	0	0	39,876	39,876	0	0	44,189	44,189	0	0	-4,313	-4,313
Adult Services	66,574	5,342,082	0	5,408,656	63,077	4,603,161	0	4,666,238	3,497	738,921	0	742,417
Adult Social Work	0	2,099,480	0	2,099,480	0	2,126,910	0	2,126,910	0	-27,429	0	-27,429
Community Care Resources	0	10,305,222	0	10,305,222	0	9,511,227	0	9,511,227	0	793,995	0	793,995
Criminal Justice	0	15,539	0	15,539	0	4,929	0	4,929	0	10,610	0	10,610
Speech & Language Therapy	81,180	0	0	81,180	76,991	0	0	76,991	4,189	0	0	4,189
Dietetics	103,764	0	0	103,764	89,809	0	0	89,809	13,955	0	0	13,955
Podiatry	222,588	0	0	222,588	213,581	0	0	213,581	9,007	0	0	9,007
Orthotics	137,409	0	0	137,409	138,258	0	0	138,258	-849	0	0	-849
Physiotherapy	585,232	0	0	585,232	560,667	0	0	560,667	24,565	0	0	24,565
Occupational Therapy	184,383	1,382,767	0	1,567,150	168,047	1,367,915	0	1,535,962	16,336	14,852	0	31,188
Health Improvement	0	0	337,348	337,348	0	0	324,233	324,233	0	0	13,116	13,116
Unscheduled Care	0	0	3,289,230	3,289,230	0	0	3,720,671	3,720,671	0	0	-431,441	-431,441
Renal	0	0	138,967	138,967	0	0	157,210	157,210	0	0	-18,243	-18,243
	18,151,173	21,308,691	4,927,285	44,387,150	19,056,838	19,264,575	5,309,094	43,630,507	-905,665	2,044,116	-381,808	756,643

3.10 The outturn position to the end of March 2016 is an overall favorable variance of £757k which represents an under spend in SIC of £2.044m and an over spend in NHSS of £1.287m.

3.11 The main reasons for the variances from budget are explained below;

3.11.1 Mental Health

The anticipated closure of Viewforth Care Home took place sooner than expected, leading to a £292k underspend within Mental Health. The savings from the Viewforth Care Home closure is a recurring saving to be recognised as part of the Spend to Save Project which linked Edward Thomason and Taing Care Homes.

In NHSS the underspend was due to two consultant psychiatrists only taking up their posts in July 2015 and one was at Specialty Doctor grade as opposed to consultant grade.

3.11.2 Pharmacy & Prescribing

The cost of drugs dispensed in the community, hospital and on-island high cost drugs has increased by £235k from the previous year, equivalent to 4.3%. This includes £45.8k in respect of the new medicines fund and Hepatitis C new drug cost of £163.9k, an increase of 9.9% on last year. Excluding these two issues year on year costs growth was only 3.2%.

In 2016/17 the planning assumption is that an additional £300k is required to be added to the budget to offset increased costs in 2015/16. In addition to that inflation uplift was added at 4.0% plus £50k for unspecified higher cost drugs entering the market in 2016/17.

3.11.3 Primary Care

Locum GP usage in the Lerwick Health Centre during 2015/16 was £249k. In Yell there were no issues until November when the substantive GP moved to another practice. Since then locums have been used to supplement the associate GP at a cost of £152k. Whalsay Health Centre also required locum cover during the year at a cost of £191k.

In 2016/17 Lerwick should remain within budget with GP recruitment taking place in early 2016. Locum cover will be required in Yell until principle GP is replaced in June 2016.

3.11.4 Directorate

There is an NHSS unachieved efficiency target of £407k included in the Directorate line above which will be carried forward into 2016/17.

In SIC budgets 2014/15 carry-forward funding allocated to fund modern apprenticeships was not spent in full, due to delays in getting apprentices started £97k (one-off saving);

There was further underspend in employee costs of £104k, of which £65k, relates to 2014/15 carry-forward funding for training back-fill and a proposed temporary joint ICT post shared with NHS Shetland which was not recruited to.

The remainder reflects underspend in the original budgets set for training back-fill and maternity benefit held within the Directorate for allocation as required.

3.11.5 Adult Services

Vacant posts across Adult Services, mainly within the Eric Gray Resource Centre and Supported Living and Outreach, some of which have been filled, but recruitment continues £286k (one-off saving). This includes 2014/15 carry-forward funding of £12k for training back-fill unused.

Budgeted borrowing costs of £188k in respect of the replacement Eric Gray building not spent in 2015/16 due to slippage in the project (one-off saving).

Budgeted Capital Funded by Current Revenue, meant to fund the Eric Gray Resource Centre Replacement, which was not required in the year £177k (one-off saving).

Increased charging income of £51k, as income levels are difficult to predict and vary depending on individual financial circumstances of those receiving care £34k (one-off saving) and projected additional income from supported tenancies at Seaview, which was not budgeted for in 2015/16 £17k (recurring saving).

3.11.6 Community Care Resources

Vacancies across Community Care Resources during the year, due to difficulty in recruitment and retention of social care workers £674k (one-off saving). This includes 2014/15 carry-forward funding of £21k for training back-fill unused and is off-set by expenditure on agency workers (£46k).

Reduction in car allowance/mileage costs as a result of vacancies £99k (one-off saving).

Increased income from charging for board and accommodation and other non-residential charges £180k (one-off saving) and a reduction in top-up payments due to Crossreach for provision of services at Walter and Joan Gray Home £76k (one-off saving), both of which can vary considerably due to the changing customer base and their individual financial circumstances.

Reduction in projected income from sale of meals as the overall uptake of meals has fallen (£40k).

Additional expenditure to replace flooring at Edward Thomason House, replace the kitchen at Overtonlea and upgrade the nurse call systems in all care homes (£63k).

All of the savings will be one-off in the current year.

3.11.7 Unscheduled Care

Medical locums were used throughout the year to cover at a cost of £284k. This was primarily due to difficulty in filling the junior doctor posts. Nursing acuity pressures resulted in overspends to pay budgets in Ward 3, Accident & Emergency and Ronas Ward.

3.12 Remuneration Report – The Local Authority Accounts (Scotland) Regulations 2014 require IJBs in Scotland to provide a Remuneration Report within the Annual Accounts. The requirement of the Regulations is that the IJB discloses the remuneration of the Chief Officer only. The IJB does not pay allowances or remuneration to voting Board members. Voting Board members are remunerated by their parent organisation and receive expenses from their parent organisation.

3.13 Related Party Transactions - The IJB is required to disclose transactions made with bodies that may have the potential to control or influence the IJB or to be controlled or influenced by the IJB in relation to integrated health and social care functions.

3.14 Public Inspection - Section 101 of the Local Government (Scotland) Regulations 1973 requires the IJB to make all supporting records used to compile the unaudited Annual Accounts available for public inspection.

The 2014 Regulations standardise the public notice and inspection period and stipulate that it must commence no later than 1 July 2016 for all IJBs.

4. Conclusions

The unaudited Annual Accounts, after consideration by the IJB, will be made available for public inspection from Friday 1 July to Thursday 21 July 2016 and will be subject to audit for a period of up to three months. The unaudited Annual Accounts will also be published on the websites of Shetland Islands Council and NHS Shetland following approval by the IJB.

The IJB is required to publish on the websites of the partner organisations its signed audited Annual Accounts and the Audit Certificate by 31 October. The Annual Audit Report is required to be published on these websites by 31 December.

Contact Details:
For further information please contact:
Karl Williamson, NHS Head of Finance & Procurement / IJB Chief Financial Officer
karlwilliamson@nhs.net Tel 01595 743301
02nd June 2016

Appendices
Appendix 1 - Annual Accounts 2015/16 Unaudited

Shetland Health and Social Care Partnership

NHS
Shetland

Annual Accounts 2015/16 Unaudited

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Introduction

The Shetland Health and Social Care Partnership (Integration Joint Board) is a body corporate, established by Parliamentary Order under section 9 of the Public Bodies (Joint Working) (Scotland) Act 2014, on 27 June 2015.

The Parties:

Shetland Islands Council ("the Council" or "SIC"), established under the Local Government etc (Scotland) Act 1994

Shetland Health Board ("the Health Board" or "NHS Shetland"), established under section 2(1) of the National Health Service (Scotland) Act 1978 (operating as Shetland NHS Board)

The Parties agreed the Integration Scheme of Shetland Island Health and Social Care Partnership, which sets out the delegation of function by the Parties to the Integration Joint Board.

The Shetland Health and Social Care Partnership Members for 2015/16 were as follows:

Voting Members:

Mr C Smith (Chairperson)
Ms C Waddington (Vice Chairperson)
Mr G Cleaver (SIC Member)
Mr B Fox (SIC Member)
Mr K Massey (NHS Shetland)
Mrs M Williamson (NHS Shetland)

Non-Voting Members:

Mr S Bokor-Ingram (Chief Officer)
Mr K Williamson (Chief Financial Officer)
Ms S Beer (Carers' Representative)
Mrs K Hughson (Third Sector Representative)
Mr H Massie (Patient/Service User Representative)
Mrs M Nicolson (Chief Social Work Officer)
Dr S Bowie (GP Representative)
Ms E Watson (Lead Nurse for the Community)
Mr I Sandilands (Staff Representative)
Ms S Gens (Staff Representative)
Mr J Unsworth (Senior Consultant: Local Acute Sector)

Management Commentary

The purpose of the Management Commentary is to inform all users of these Accounts and help them to understand the most significant aspects of Shetland Health and Community Care Partnership's financial performance from its establishment on 27 June 2015 to 31 March 2016, and its financial position as at 31 March 2016.

Background

Integration of health and social care is the Scottish Government's ambitious programme of reform to improve services for people who use health and social care service. Integration will ensure that health and social care provision across Scotland is joined-up and seamless, especially for people with long term conditions and disabilities, many of whom are older people.

The new Public Bodies (Joint Working) (Scotland) Act was granted royal assent on 1 April 2014. Shetland Islands Council and the Board of NHS Shetland took the decision that the Model of integration of health and social care services in Shetland would be the Body Corporate, known as an Integrated Joint Board.

Under the Body Corporate model, the Health Board and the Council delegate the responsibility, for planning and resourcing service provision of adult health and social care services to an Integration Joint Board.

Integration Joint Board (IJB) was established as a Body Corporate by order of Scottish Ministers on 27 June 2015 and the inaugural meeting, which confirmed the full membership of the IJB, was held on 20 July 2015. The IJB approved their Standing Orders, Scheme of Administration and Financial Regulation at their second meeting on 29 July 2015.

As a separate legal entity the IJB has full autonomy and capacity to act on its own behalf and can, accordingly, make decision about the exercise of its functions and responsibilities as it sees fit.

The IJB is responsible for the strategic planning of the functions delegated to it by SIC and NHS Shetland. The Strategic Plan specifies the service to be delivered by the Parties. The IJB is responsible for ensuring the delivery of its functions through the locally agreed operational arrangements set out within its Integration Scheme.

The practical application of the Integration Scheme will be managed and administered in accordance with the Financial Regulations, Standing Orders and Scheme of Administration of the Parties as amended to meet the requirements of the Act.

The IJB approved its Joint Strategic Commissioning Plan 2015-16 on 20 November 2015.

Purpose and Objectives

The main purpose of integration is to improve the wellbeing of people who use health and social care services, particularly those whose needs are complex and involve support from health and social care at the same time. The Integration Scheme is intended to achieve the National Health and Wellbeing Outcomes prescribed by the Scottish Ministers in Regulations under section 5(1) of the Act:

National Health and Wellbeing Outcomes

1. People are able to look after and improve their own health and wellbeing and live in good health for longer.
2. People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
5. Health and social care services contribute to reducing health inequalities.
6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.
7. People using health and social care services are safe from harm.
8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
9. Resources are used effectively and efficiently in the provision of health and social care.

The following objectives were set out in the Shetland Joint Strategic Commissioning Plan 2015-16;

- That the main purpose of services which are provided to meet integration functions is to improve the wellbeing of services users
- That, in so far as consistent with the main purpose, those services be provided in a way which, so far as possible:
  - is integrated from the point of view of service-users
  - takes account of the particular needs of different service-users
  - takes account of the particular needs of service-users in different parts of the area in which the service is being provided
  - takes account of the particular characteristics and circumstances of different service-users
  - respects the rights of service-users
  - takes account of the dignity of service-users
  - takes account of the participation by service-users in the community in which service-users live
  - protects and improves the safety of service-users
  - improves the quality of the service
  - is planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care)
  - best anticipates needs and prevents them arising
  - makes the best use of the available facilities, people and other resources

Operational Review

During 15/16 there was a continued focus on reducing delayed discharges from hospital. Performance was much improved from the previous winter in 14/15, with an overall reduction in the number of delays at any one time, and reducing lengths of delay for individuals. This work has extended through the entire patient/client pathway journey, along with initiatives funded through the Integrated Care Fund including intermediate care and third sector provision.

The balance of care in Shetland remains very good, with less care centre bed usage than the national average, and more people with high needs being cared for in their own homes. The implementation of the With You For You Review of our joint assessment process has continued at pace,

and staff training as part of the implementation has seen better goal orientated outcomes for individual clients. This will underpin our continuing journey to maintain an ageing population in community based settings, and tailoring support for fulfilling lives in older age.

Staff is our greatest asset, and it is pleasing to see sickness rates reducing over the course of the year. Whilst the rate remains high compared to other SIC Directorates, nonetheless this is the second year that rates have improved. We held open staff meetings in each of the 7 planning localities, and heard how teams are working together, and what more we need to do to remove barriers to joint working. This will start to be addressed in 16/17.

The operational management team had a continued challenge to find further efficiencies, and whilst the Council part of the budget has under spent, considerable pressures remain in the Health Board budget which will require continued attention in 2016/17 in order to achieve a balanced position.

Primary Financial Statements

The Annual Accounts detail Shetland Health and Social Care Partnership's transactions for the period from 27 June 2015 to 31 March 2016. The Annual Accounts are prepared in accordance with the International Accounting Standards Board (IASB) Framework for the Preparation and Presentation of Financial Statements (IASB Framework) as interpreted by the Code of Practice on Local Authority Accounting in the United Kingdom.

A description of the purpose of the primary statements has been included immediately prior to each of the financial statements: the Statement of Income and Expenditure for the period from 27 June 2015 to 31 March 2016 and the Balance Sheet. These Statements are accompanied by Notes to the Accounts which set out the Accounting Policies adopted by the Partnership and provide more detailed analysis of the figures disclosed on the face of the primary financial statements.

The primary financial statements and notes to the accounts, including the accounting policies, form the relevant Annual Accounts for the purpose of the auditor's certificate and opinion.

Remuneration of the Chief Officer of the Partnership is disclosed in the Remuneration Report.

Financial Review

The Strategic Commissioning Plan 2015/16 sets out the functions which have been delegated by the Parties and the associated agreed budgets. The Plan was agreed by IJB Members on 20 November 2015. As defined in the Public Bodies (Joint Working) (Scotland) Act 2014, Section 29 (6), this is considered the "integration start day".

The Accounts include the part year contributions from the Parties, representing 19 weeks of the annual agreed budgets. Similarly, part year payments to the Parties from the IJB for carrying out its directions have been made based on the 19 week period from the integration start date to 31 March 2016.

Running costs for the IJB have been included from the establishment date.

The purpose of the Annual Accounts is to present a public statement on the stewardship of funds for the benefit of both Members of the IJB and the public. The IJB is funded by Shetland Islands Council (SIC) and Shetland Health Board (NHSS).

The Statement of Income and Expenditure presents the full economic cost of providing the Board's services in 2015/16 from the date of establishment to 31 March 2016.

The IJB is presenting a breakeven position in 2015/16 even though there were significant variances in both arms of the operational budget. This is due to the fact that the under spend in the SIC arm of the budget was fortuitous and was therefore returned to the SIC as per the Integration Scheme. Likewise the over spend in the NHSS arm of the budget had to be funded by additional contributions from the NHSS.

The Integration Scheme states that where there is a planned, forecast, under spend on an element of the operational budget due to agreed changes in line with the Strategic Plan, this will be retained by the IJB to either fund other service areas in-year in line with the Strategic Plan or be carried forward to fund services in subsequent years of the Strategic Plan. However, any windfall under spend will be returned to the Council and/or the Health Board in line with the original budget allocation for 2015/16.

Where there is a forecast over spend against an element of the operational budget, the Chief Officer and the Chief Finance Officer of the Integration Joint Board will work with the Local Partnership Finance Team and the appropriate finance officers of the Parties to agree a recovery plan to balance the overspending budget. The recovery plan shall be subject to the approval of the IJB.

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6 Additional contribution from NHS to IJB to meet overspend	-	(367)	(367)
7 Final balanced position of IJB	-	-	-

The table below details the full year financial position for the IJB and is broken down by service area. Although the accounts are apportioned to represent the period from 20 November 2015 (the date the functions were delegated) to 31 March 2016, the full year analysis provides a more meaningful summary.

Service Heading	ANNUAL BUDGET				OUTTURN				OUTTURN VARIANCE			
	JOINT BUDGETS		SET ASIDE		JOINT BUDGETS		SET ASIDE		JOINT BUDGETS		SET ASIDE	
	NHS	SIC	BUDGET	TOTAL	NHS	SIC	BUDGET	TOTAL	NHS	SIC	BUDGET	TOTAL
	£	£	£	£	£	£	£	£	£	£	£	£
Mental Health	1,318,107	1,347,701	0	2,665,808	1,298,925	1,091,149	0	2,390,074	19,182	256,553	0	275,735
Substance Misuse	570,117	254,519	0	824,636	562,731	209,310	0	772,041	7,386	45,209	0	52,595
Oral Health	3,253,206	0	0	3,253,206	3,281,661	0	0	3,281,661	-28,455	0	0	-28,455
Pharmacy & Prescribing	4,916,057	0	1,121,864	6,037,921	5,173,668	0	1,062,790	6,236,458	-257,611	0	59,074	-198,537
Primary Care	4,563,657	0	0	4,563,657	4,904,407	0	0	4,904,407	-340,750	0	0	-340,750
Community Nursing	2,387,175	0	0	2,387,175	2,355,228	0	0	2,355,228	31,947	0	0	31,947
Directorate	-238,276	561,381	0	323,105	169,786	349,975	0	519,761	-408,062	211,406	0	-196,656
Pensioners	0	0	0	0	0	0	0	0	0	0	0	0
Sexual Health	0	0	39,876	39,876	0	0	44,189	44,189	0	0	-4,313	-4,313
Adult Services	66,574	5,342,082	0	5,408,656	63,077	4,603,161	0	4,666,238	3,497	738,921	0	742,417
Adult Social Work	0	2,099,480	0	2,099,480	0	2,126,910	0	2,126,910	0	-27,429	0	-27,429
Community Care Resources	0	10,305,222	0	10,305,222	0	9,511,227	0	9,511,227	0	793,995	0	793,995
Criminal Justice	0	15,539	0	15,539	0	4,929	0	4,929	0	10,610	0	10,610
Speech & Language Therapy	81,180	0	0	81,180	76,991	0	0	76,991	4,189	0	0	4,189
Dietetics	103,764	0	0	103,764	89,809	0	0	89,809	13,955	0	0	13,955
Podiatry	222,588	0	0	222,588	213,581	0	0	213,581	9,007	0	0	9,007
Orthotics	137,409	0	0	137,409	138,258	0	0	138,258	-849	0	0	-849
Physiotherapy	585,232	0	0	585,232	560,667	0	0	560,667	24,565	0	0	24,565
Occupational Therapy	184,383	1,382,767	0	1,567,150	168,047	1,367,915	0	1,535,962	16,336	14,852	0	31,188
Health Improvement	0	0	337,348	337,348	0	0	324,233	324,233	0	0	13,116	13,116
Unscheduled Care	0	0	3,289,230	3,289,230	0	0	3,720,671	3,720,671	0	0	-431,441	-431,441
Renal	0	0	138,967	138,967	0	0	157,210	157,210	0	0	-18,243	-18,243
	18,151,173	21,308,691	4,927,285	44,387,150	19,056,838	19,264,575	5,309,094	43,630,507	-905,665	2,044,116	-381,808	756,643

The outturn position to the end of March 2016 is an overall favorable variance of £757k which represents an under spend in SIC of £2.044m and an over spend in NHSS of £1.287m.

The main reasons for the variances from budget are explained below;

Mental Health

The anticipated closure of Viewforth Care Home took place sooner than expected, leading to a £292k underspend within Mental Health.

Pharmacy & Prescribing

The cost of drugs dispensed in the community, hospital and on-island high cost drugs has increased by £235k from the previous year, equivalent to 4.3%. This includes £45.8k in respect of the new medicines fund and Hepatitis C new drug cost of £163.9k, an increase of 9.9% on last year. Excluding these two issues year on year costs growth was only 3.2%.

Primary Care

Locum GP usage in the Lerwick Health Centre during 2015/16 was £249k. In Yell there were no issues until November when the substantive GP moved to another practice. Since then locums have been used to supplement the associate GP at a cost of £152k. Whalsay Health Centre also required locum cover during the year at a cost of £191k.

Directorate

There is an NHSS unachieved efficiency target of £407k included in the Directorate line above which will be carried forward into 2016/17.

The SIC Directorate budgets included 2014/15 carry-forward funding of £278k, of which £162k was underspent due to delays in getting modern apprenticeship underway, inability to utilise budget provided to back-fill training of staff due to level of vacancies and non-recruitment to a planned joint temporary ICT post within the Directorate.

Adult Services

Due to difficulty in recruiting and retaining staff, there was an underspend in employee costs of £286k. Budgets had been set aside to cover borrowing costs (£188k) and also allow revenue to be transferred to cover initial capital costs (£177k) of the replacement Eric Gray Centre, but due to delay in the start of this project were not required.

Community Care Resources

Due to difficulty in recruiting and retaining staff, there was an underspend in employee costs of £674k. This also meant that car allowance and mileage payment were £99k less than anticipated. Income charges for Board and Accommodation were £168k more than expected, but this can vary from year to year as it is dependent on the financial circumstances of those people receiving care. This has been off-set by expenditure on Reshaping Care and Integrated Care Fund for which contingency was available if required, but has been met from the overall underspend.

The Balance Sheet as at 31 March 2016

The IJB does not own any fixed assets or inventories and has no bank account or cash of its own. Due to the contributions to/from the SIC and NHSS being equal in 2015/16 the Balance Sheet has a zero value.

2016/17 Budget and Medium Term Financial Outlook

The 2016/17 budget has been approved on 28th June 2016 as part of the 2016/17 Strategic Commissioning Plan. The plan also contains an indicative budget allocation for 2017/18 and 2018/19.

The Shetland IJB, like all others, faces significant financial challenges and is required to operate within tight fiscal constraints for the foreseeable future due to the continuing difficult national economic outlook and increasing demand for services. Additional funding of £250m was announced for Health and Social Care Partnerships for 2016/17 to address social care pressures, as well as providing funding to offset the costs of the national Living Wage and reduced income through increased charging thresholds. Despite this additional funding, pressures continues on public sector expenditure at a UK and Scottish level with further reductions in government funding predicted in 2018/19.

The anticipated reduction in funding coupled with the demographic challenges which Shetland is facing, results in key risks which can be summarised as follows:

- Increased demand for services alongside reducing resources;
- The wider financial environment which continues to be challenging; and
- Political uncertainty including Scottish Parliament and local elections in the next two years, as well as the financial powers arising from the Scotland Act 2012 and recommendations arising from the Smith Commission.

There is currently a shortfall in the NHS funding to the IJB in 2016/17 of £1.777m. A recovery plan has been agreed but it will be very challenging to deliver in year. Progress on the recovery plan will be closely monitored throughout the year to identify any slippage for the plan early to allow remedial action.

Acknowledgement

We would like to acknowledge the significant effort of all the staff across the IJB who contributed to the preparation of the Annual Accounts and to the budget managers and support staff whose financial stewardship contributed to the favourable financial position at 31 March 2016.

....

Simon Bokor-Ingram
Chief Officer Date

....

Cecil Smith Date
Chair

21/06/2016

Karl Williamson Date
Chief Financial Officer

Annual Governance Statement

Scope of Responsibility

The Integration Joint Board (IJB) is responsible for ensuring that its business is conducted in accordance with the law and appropriate standards, that public money is safeguarded, properly accounted for, and used economically, efficiently and effectively. The IJB also aims to foster a culture of continuous improvement in the performance of the IJB's functions and to make arrangements to secure Best Value.

In discharging these responsibilities, the Chief Officer has a reliance on the systems of internal control of both Shetland NHS Board (the Health Board) and Shetland Islands Council (the Council) that support compliance with both organisations' policies and promote achievement of each organisation's aims and objectives, as well as those of the IJB.

The IJB has adopted a Local Code of Corporate Governance ("the Local Code") consistent where appropriate with the six principles of CIPFA and the Society of Local Authority Chief Executives (SOLACE) framework "*Delivering Good Governance in Local Government*". This statement explains how the IJB has complied with the Local Code and also meets the Code of Practice on Local Authority Accounting in the UK, which details the requirement for an Annual Governance Statement.

Purpose of Internal Control

The system of internal control is based on an ongoing process designed to identify, prioritise and manage the risks facing the organisation. The system aims to evaluate the nature and extent of failure to achieve the organisation's policies, aims and objectives and to manage risks efficiently, effectively and economically. As such it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control has been in place at the IJB for the financial year ended 31 March 2016 and up to the date of the approval of the Statement of Accounts.

The Governance Framework

The Board of the IJB comprises the Chair and 5 Members with voting rights; 3 are Council Members appointed by the Council and 3 are Health Board Members appointed by the Health Board from among those

Members of the local NHS system appointed by Scottish Ministers. The IJB via a process of delegation from the Health Board and the Council has responsibility for the planning, resourcing and operational delivery of all integrated health and social care within its geographical area through its Chief Officer. The IJB also has strategic planning responsibilities for a range of acute health services for which the budget is "set aside".

The main features of the IJB's system of internal control are summarised below.

- The overarching strategic vision and objectives of the IJB are detailed in the IJB's Integration Scheme which sets out the key outcomes the IJB is committed to delivering through the Council and the Health Board as set out in the IJB's Strategic Plan and Annual Financial Statement.
- Services are able to demonstrate how their own activities link to the IJB's vision and priorities through their Corporate Improvement Plans and Service Plans.
- Performance management, monitoring of service delivery and financial governance is provided through quarterly reports to the IJB as part of the Planning and Performance Management Framework. Quarterly reports include financial monitoring of the integrated budget and the "set aside" budget, the IJB Risk Registers, performance against national outcome measures, local outcome measures and service development projects. The IJB also receives regular reports from the joint Council, Health Board and IJB Clinical, Care and Professional Governance Committee and the IJB Audit Committee.
- The Participation and Engagement Strategy sets out the IJB's approach to engaging with stakeholders. Consultation on the future vision and activities of the IJB is undertaken collaboratively with the Council and the Health Board and through existing community planning networks. The IJB publishes information about its performance regularly as part of its public performance reporting.
- The IJB operates within an established procedural framework. The roles and responsibilities of Board Members and officers are defined within Standing Orders, Scheme of Administration and Financial Regulations; these are subject to regular review.
- Effective scrutiny and service improvement activities are supported by the formal submission of reports, findings and recommendations by Audit Scotland, the external auditors, national inspection agencies and the appointed Internal Audit service to the IJB's

Senior Management Team, to the IJB and the main Board and Audit Committee.

- The IJB follows the principles set out in CoSLA's *Code of Guidance on Funding External Bodies and Following the Public Pound* for both resources delegated to the Partnership by the Health Board and the Council and resources paid to its Council and Health Board Partners.
- Responsibility for maintaining and operating an effective system of internal financial control rests with the Chief Financial Officer. The system of internal financial control is based on a framework of regular management information, Financial Regulations and Standing Financial Instructions, administrative procedures (including segregation of duties), management and supervision, and a system of delegation and accountability. Development and maintenance of the system is undertaken by managers within the IJB.
- The IJB's approach to risk management is set out in the Integration Scheme and IJB Risk Management Strategy. Reports on risk management are considered regularly by the H&SC Management Team with quarterly reporting on the IJB Risk Registers to the IJB Board and an annual report to the IJB Audit Committee.
- The IJB has adopted a code of conduct for its employees. IJB Board Members observe and comply with the Nolan Seven Principles of Public Life. Comprehensive arrangements are in place to ensure IJB Board Members and officers are supported by appropriate training and development.
- Staff are made aware of their obligations to protect client, patient and staff data. The NHS Scotland *Code of Practice on Protecting Patient Confidentiality* has been issued to all NHS Shetland staff working in IJB directed services and all staff employed by the Council working in IJB directed services have been issued with the SSSC Codes of Practice.
- Employee Codes of Conduct within the partner organisations set out the requirement for employee confidentiality. The Joint Staff Forum provides a mechanism for discussing concerns and issues affecting staff governance and the workforce within integrated services that enable the early identification of potential workforce risks.

Review of Adequacy and Effectiveness

The IJB has responsibility for conducting at least annually, a review of effectiveness of the system of internal control and the quality of data used throughout the organisation. The review is informed by the work of the Service Managers within the Council and the Health Board (who have responsibility for the development and maintenance of the internal control framework environment), the work of the internal auditors, the Chief Internal Auditor's annual report, and reports from external auditors and other review agencies and inspectorates.

The review of the IJB's governance framework is supported by a process of self-assessment and assurance certification by Directors within the Council and the Health Board. The IJB directs the Council and the Health Board to provide services on its behalf and does not provide services directly. Therefore, the review of the effectiveness of the governance arrangements and systems of internal control within the IJB places reliance upon the individual bodies' management assurances in relation to the soundness of their systems of internal control.

There was one significant internal control issue identified by the review regarding the 2016/17 savings target and another 4 issues worthy of noting – see the table below. A recovery plan has been developed to address the 2016/17 savings target but this will need developed and refined during the year. We propose over the coming year to take steps to address all these matters to further enhance our internal control arrangements. We are satisfied that these steps will address the need for improvements which were identified in our review of effectiveness and will monitor their implementation and operation as part of our next annual review.

Roles and Responsibilities of the Audit Committee and Chief Internal Auditor

IJB Members and officers of the IJB are committed to the concept of sound internal control and the effective delivery of IJB services. The IJB's Audit Committee operates in accordance with CIPFA's Audit Committee Principles in Local Authorities in Scotland and Audit Committees: Practical Guidance for Local Authorities.

The Audit Committee performs a scrutiny role in relation to the application of CIPFA's Public Sector Internal Audit Standards 2013 (PSIAS) and reviews the performance of the IJB's Internal Audit Service.

The appointed Chief Internal Auditor has responsibility to review independently and report to the Audit Committee annually, to provide assurance on the adequacy and effectiveness of the IJB's system of internal control.

The internal audit service undertakes an annual programme of work, approved by the Audit Committee, based on a strategic risk assessment. The appointed Chief Internal Auditor provides an independent opinion on the adequacy and effectiveness of internal control.

The Chief Internal Auditor has conducted a review of all Internal Audit reports issued in the financial year that relate to the IJB (2 Scott Moncrieff internal audit reports: 1) Integration Assurance, due diligence and governance arrangements 2) Review of governance, risk management and project management of the Integration Board. In conclusion, although no system of internal control can provide absolute assurance nor can Internal Audit give that assurance, on the basis of audit work undertaken during the reporting period, there have been no significant issues reported by Internal Audit.

Furthermore, on the basis of the audit work undertaken during the reporting period, the Chief Internal Auditor is able to conclude that a reasonable level of assurance can be given that the system of internal control is operating effectively within the organisation.

Compliance with Best Practice

The IJB complies with the CIPFA Statement on "*The Role of the Chief Financial Officer in Local Government 2010*". The IJB's Chief Finance Officer has overall responsibility for the IJB's financial arrangements and is professionally qualified and suitable experienced to lead the IJB's finance function and to direct finance staff in both partner organisations to ensure the effective financial management of the IJB. The Chief Financial Officer has direct access to the Director of Finance in Shetland NHS Board and the Executive Manager – Finance in Shetland Islands Council to address financial issues and is a member of the Local Partnership Finance Team.

The Partnership complies with the requirements of the CIPFA Statement on "*The Role of the Head of Internal Audit in Public Organisations 2010*". The IJB's appointed Chief Internal Auditor has responsibility for the IJB's internal audit function and is professionally qualified and suitably experienced to lead and direct internal audit staff. The Internal Audit

service generally operates in accordance with the CIPFA "*Public Sector Internal Audit Standards 2013*".

Internal Control Issues and Planned Actions

The IJB continues to recognise the need to exercise strong management arrangements to manage the pressures common to all public bodies. Regular reviews of the IJB's arrangements are undertaken by the appointed internal auditors and overall the IJB's arrangements are sound. The table below sets out improvement actions to the system of internal control identified from the IJB's ongoing review and monitoring of its governance arrangements. These represent corporate initiatives that will be undertaken or further progressed during the next financial period.

	Where are we now?	*Where do we want to be?*	*How will we know we are getting there?*	*Who is responsible?*
	1 Financial Assurance: The Integration Scheme outlines various protocols to be followed in particular situations. It is less clear how these will work in practice. The shortfall in funding from the Health Board reflected in the IJB budget for 2016/17 has to some extent been addressed; however, it is not yet clear how the required savings will be made.	*a) Detailed Annual Accounts financial transactions to be developed and understood. b) An achievable detailed recovery plan for the shortfall in funding from the Health Board agreed and approved by the IJB.*	*a) Detailed processes and transactions have been developed and will be reviewed by external audit during the annual accounts process. b) Recovery Plan approved by IJB and Financial Monitoring Reports evidencing adherence to*	*a) Chief Financial Officer b) Chief Officer*

			plan.	
	2 IJB Governance: An up to date version of the Joint Strategic Commissioning Plan must be maintained in order to reflect the evolving financial position and to comply with the Public Bodies (Joint Working) (Scotland) Act 2014.	*A fully agreed and approved Strategic (Commissioning) Plan with detailed budgets for 2016/17 and outline budgets for 2017/18 and 2018/19.*	*When plan has been approved by the IJB.*	*Chief Officer*
	3 IJB Governance: Consideration should be given to developing formal training needs assessments for members of the IJB.	*A formal training needs assessment should be carried out and subsequent action plans developed.*	*Action plans in place.*	*Chief Officer*
	4 IJB Governance: Register of Interest forms should be completed and maintained for all members of the IJB in line with IJB Standing Orders Para 5.7.1.	*Completed Register of Interests forms for all members*	*Completed Register of Interests forms for all members*	*Chief Officer*
	5 Risk Management: Consideration should be given to risk management reports having a dedicated item on the agenda in	*Risk management reports being on the agenda in relation to risk management*	*When risk manageme nt reports are on the agenda in*	*Chief Officer*

	relation to risk management issues each quarter. Within this report, IJB strategic risks and services' risks should be reported separately.	*issues each quarter. Within this report, IJB strategic risks and services' risks are reported separately.*	*relation to risk manageme nt issues each quarter. Within this report, IJB strategic risks and services' risks are reported separately.*	

Assurance

Subject to the above, and on the basis of assurances provided, we consider that the internal control environment operating during the reporting period provides reasonable and objective assurance that any significant risks impacting upon the achievement of our principal objectives will be identified and actions taken to avoid or mitigate their impact. Systems are in place to continually review and improve the internal control environment and action plans are in place to identify identified areas for improvement.

Certification

It is our opinion that reasonable assurance, *subject to the matters noted above,* can be placed upon the adequacy and effectiveness of the Integration Joint Board's systems of governance.

.....	.....
Simon Bokor-Ingram	Cecil Smith
Chief Officer	Chair
.....	.....
Date	Date

Remuneration Report

Introduction

The Local Authority Accounts (Scotland) Regulations 2014 (SSI 2014/200) require local authorities and IJBs in Scotland to prepare a Remuneration Report as part of their annual statutory accounts.

Integration Joint Board

The voting members of the Integration Joint Board shall comprise three persons appointed by NHS Shetland (NHSS), and three persons appointed by the Shetland Islands Council (SIC), as follows:

Member	Nominating Organisation(s)	Appointing Organisation
3 NHS Non-Executive Board Members Ms C Waddington (Vice Chairperson) Mr K Massey Mrs M Williamson	N/A	NHSS
3 Councillors Mr C Smith (Chairperson) Mrs G Cleaver Mr B Fox	N/A	SIC

The professional advisors to the IJB are non-voting members. These are identified as follows:

Member	Nominating Organisation(s)	Appointing Organisation
Chief Officer	SIC/NHSS	IJB
Chief Financial Officer (Section 95 Officer)	SIC/NHSS	IJB
Chief Social Worker Officer	N/A	SIC
General Practitioner Representative	NHSS	IJB
Senior Consultant: Local Acute Sector	NHSS	IJB
Lead Nurse for the Community	NHSS	IJB

Staff Representative	NHSS	IJB
Staff Representative	SIC	IJB
Third Sector Representative	Voluntary Action Shetland	IJB
Patient/Service User Representative	Public Partnership Forum	IJB
Carers' Representative	Carers' Link Group	IJB

Senior officers

The IJB does not directly employ any staff. All Partnership officers are employed by either NHS Shetland or Shetland Islands Council, and remuneration to senior staff is reported through the employing organisation.

The Chief Officer, Simon Bokor Ingram, was appointed as Director of Community Health and Social Care on 1 February 2014, and formally appointed as Chief Officer of the Integration Joint Board on 20 July 2015 in consultation with Shetland Islands Council and NHS Shetland.

The Chief Officer is employed by NHS Shetland but this is a joint post with Shetland Islands Council, with 50% of his cost being recharged to the Council. Performance appraisal and terms and conditions of service are in line with NHS Scotland circulars and continuity of service applies. Formal line management is provided through the Chief Executive, NHS Shetland, but Director of Community Health and Social Care is accountable to both the Chief Executive of NHS Shetland and the Chief Executive of Shetland Islands Council.

The IJB approved the appointment of the Chief Financial Officer at its meeting on 20 July 2015. The role of Chief Financial Officer for the IJB is carried out by the NHS Shetland Head of Finance, Karl Williamson, with NHS Shetland meeting his full cost.

Remuneration policy

The IJB does not pay allowances or remuneration to the voting board members. Voting board members are remunerated by their parent organisation and receive expenses from their parent organisation. The cost of any Member expenses which were wholly, exclusively and necessarily incurrered on IJB business during the period have been charged to the IJB, with NHS Shetland and Shetland Islands Council

providing equal additional contributions to meet the cost. The level of expenses is not material.

Remuneration

The Chief Officer received the following remuneration in the year:

	2015/16 Salary, fees and allowances £	2015/16 Taxable expenses £	2015/16 Total Remuneration £
Simon Bokor Ingram	91,947	0	91,947
Total	**91,947**	**0**	**91,947**

Pension benefits

The Chief Officer participates in the National Health Service Superannuation Scheme (Scotland). The scheme is an unfunded statutory public service pension scheme with benefits underwritten by the UK Government. The scheme is financed by payments from employers and from those current employees who are members of the scheme and paying contributions at progressively higher marginal rates based on pensionable pay, as specified in the regulations.

For more information on the National Health Service Superannuation Scheme (Scotland) please see the link below.

http://www.sppa.gov.uk/index.php?option=com_content&view=article&id=43&Itemid=4

Pension entitlement for the Chief Officer for the year to 31 March 2016 is shown in the table below, together with the contribution made by the employing body to this pension during the year.

	In-year Employer Pension Contributions 31 March 2016 £	Accrued Annual Pension Benefits 31 March 2016 £	Lump sum Entitlement 31 March 2016 £
Simon Bokor Ingram	13,700	25,918	72,645
Total	**13,700**	**25,918**	**72,645**

.....	.....
Simon Bokor-Ingram	Cecil Smith
Chief Officer	Chair
.....	.....
Date	Date

Statement of Responsibilities for the Annual Accounts

The Integration Joint Board's Responsibility

The Integration Joint Board is required to:

- make arrangements for the proper administration of its financial affairs and to secure that the proper officer has the responsibility for the administration of those affairs (section 95 of the Local Government (Scotland) Act 1973). In this Integration Joint Board the proper officer is the Chief Financial Officer;
- manage its affairs to secure economic, efficient and effective use of resources and to safeguard its assets;
- ensure the Annual Accounts are prepared in accordance with legislation (The Local Authority Accounts (Scotland) Regulations 2014) and, so far as is compatible with that legislation, in accordance with proper accounting practices (section 12 of the Local Government in Scotland Act 2003); and
- approve the Annual Accounts for signature.

I can confirm that these Annual Accounts were approved for signature by the Integration Joint Board on 28 June 2016.

Signed on behalf of Shetland Islands Integration Joint Board

.....	.....
Cecil Smith	Date
Chair	

The Chief Financial Officer's Responsibilities

The Chief Financial Officer is responsible for the preparation of the Board's Annual Accounts in accordance with proper practices as required by legislation and as set out in the CIPFA/LASAAC Code of Practice on Local Authority Accounting in the United Kingdom (the Accounting Code).

It is the responsibility of the Chief Financial Officer to sign, date and submit the un-audited Annual Accounts to the appointed auditor by 30 June 2016.

In preparing this Annual Accounts, the Chief Financial Officer has:

- selected suitable accounting policies and then applied them consistently;
- made judgements and estimates that were reasonable and prudent;
- complied with legislation; and
- complied with the local authority Accounting Code (in so far as it is compatible with legislation).

The Chief Financial Officer has also:

- kept adequate accounting records which were up to date;
- taken reasonable steps for the prevention and detection of fraud and other irregularities.

I certify that the Annual Accounts give a true and fair view of the financial position of the Integration Joint Board and its group at the reporting date and the transactions of the Integration Joint Board and its group for the year ended 31 March 2016.

.....

Karl Williamson
Chief Financial Officer

21/06/2016

.....

Date

Statement of Income and Expenditure for period from 27 June 2015 to 31 March 2016

The **Statement of Income and Expenditure** shows the accounting costs of providing the service in accordance with generally accepted accounting practices (GAAP).

	2015/16 Gross Expenditure £000	2015/16 Gross Income £000	2015/16 Net Expenditure £000
Health Services	8,787	(233)	8,554
Social Care Services	10,239	(2,492)	7,747
Corporate Services	19	0	19
Services commissioned by IJB	**19,045**	**(2,725)**	**16,320**
Cost of provision of services	**(19,045)**	**2,725**	**(16,320)**
(Surplus)/Deficit on provision of services	**0**	**0**	**0**

Balance Sheet as at 31 March 2016

The **Balance Sheet** shows the value of the assets and liabilities recognised by the Board (ie the net worth of the entity).

	Notes	31 March 2016 £000
Short Term Debtors		16,320
Current Assets		**16,320**
Short Term Creditors		(16,320)
Current Liabilities		**(16,320)**
Net Assets		**0**
Usable Reserves		0
Unusable Reserves		0
Total Reserves		**0**

The Statement of Accounts presents a true and fair view of the financial position of the Integration Joint Board as at 31 March 2016 and its income and expenditure for the year then ended.

The unaudited Annual Accounts were authorised for issue on 28 June 2016.

..... 21/06/2016

Karl Williamson
Chief Financial Officer

Date

Notes To The Primary Financial Statements

Note 1 - Summary Of Significant Accounting Policies

General Principles

The Shetland Health and Social Care Partnership is formed under the terms of the Public Bodies (Joint Working) (Scotland) Act 2014 and is a Joint Venture between NHS Shetland and Shetland Islands Council.

Integration Joint Boards (IJBs) are specified as section 106 bodies under the Local Government (Scotland) Act 1973 and as such are required to prepare their Annual Accounts in compliance with the Code of Practice on Accounting for Local Authorities in the United Kingdom.

The Annual Accounts summarise the IJB's transactions for period from 27 June 2015 to 31 March 2016 and its position as at 31 March 2016.

The Code specifies the applicable accounting policies for:

- selecting measurement bases for recognising assets, liabilities, gains and losses in the Annual Accounts;
- making changes to reserves;
- the minimum disclosure requirements.

A valid estimation technique can be used to derive the monetary amount (i.e. the one that best reflects the economic reality of a transaction or event) to be recognised in the financial statements in such circumstances when the basis of measurement for the monetary amount cannot be applied with certainty (and the range of options is considered to be material).

Accounting Conventions and Concepts

The accounting convention adopted in the Annual Accounts is historical cost.

The concept of the IJB as a going concern is based on the premise that its functions and services will continue in existence for the foreseeable future.

The concept of materiality derives from the premise that financial statements need not be precisely accurate to represent a true and fair view. It is a matter of professional judgement as to whether users of the accounts could come to different conclusions about the IJB's standards of stewardship or make different economic decisions as a result of deviations from the provisions set out in the Code.

The accounting policies which have a significant effect on the amounts recognised in the financial statements of the IJB are summarised below.

(a) Accruals of income and expenditure

Activity is accounted for in the year that it takes place, not simply when the payments are made or received.

- revenue from the sale of goods is recognised when the Board transfers the significant risks and rewards of ownership to the purchaser and it is probable that economic benefits or service potential associated with the transaction will flow to the Board; and
- revenue from the provision of services is recognised when the Board can measure reliably the percentage of completion of the transaction and it is probable that economic benefits or service potential associated with the transaction will flow to the Board.

(b) Funding

The Integrated Joint Board receives contributions from its funding partners, namely Shetland Islands Council and NHS Shetland to fund its services. Expenditure is incurred in the form of charges for services provided to the IJB by these partners.

(c) Value Added Tax

The Integration Joint Board is a non-taxable person and does not charge or recover VAT on its functions.

(d) Provisions, contingent liabilities and assets

Provisions

Provisions are made where an event has taken place that gives the IJB a legal or constructive obligation that probably requires settlement by a transfer of economic benefits or service potential, and a reliable estimate can be made of the amount of the obligation.

Provisions are charged as an expense to the appropriate service lines in the Income and Expenditure Statement in the year that the IJB becomes aware of the obligation, and are measured at the best estimate at the Balance Sheet date of the expenditure required to settle the obligation, taking into account relevant risks and uncertainties.

When payments are eventually made, they are charged to the provision carried in the Balance Sheet. Estimated settlements are reviewed at the end of each financial year. Where it becomes less than probable that a transfer of economic benefits will now be required (or a lower settlement than anticipated is made), the provision is reversed and credited back to the relevant service.

Contingent asset and liabilities

A contingent asset or liability arises where an event has taken place that gives the IJB a possible obligation or benefit whose existence will only be confirmed by the occurrence or otherwise of uncertain future events not wholly within the control of the IJB. Contingent liabilities or assets also arise in circumstances where a provision would otherwise be made but, either it is not probable that an outflow or resources will be required or the amount of the obligation cannot be measured reliably.

Contingent assets and liabilities are not recognised in the Balance Sheet but disclosed in a note to the Accounts where they are deemed material.

(e) Events after the reporting period

Events after the Balance Sheet date are those events, both favourable and unfavourable, that occur between the end of the

reporting period and the date when the Annual Accounts is authorised for issue.

Two types of events can be identified:

- those that provide evidence of conditions that existed at the end of the reporting period whereby the Annual Accounts is adjusted to reflect such events; and
- those that are indicative of conditions that arose after the reporting period whereby the Annual Accounts is not adjusted to reflect such events, but where a category of events would have a material effect and disclosure is made in the notes of the nature of the events and their estimated financial effect.

Events taking place after the date of authorisation for issue are not reflected in the Annual Accounts.

(f) Reserves

Reserves are created by appropriating amounts out of revenue balance in the Movement in Reserves Statement. When expenditure to be financed from a reserve is incurred, it is charged to the appropriate service in that year so as to be included within the Income and Expenditure Statement. There are no reserves as at 31 March 2016, so a Movement of Reserves Statement has not been included in these Accounts.

(g) Corresponding Amounts

The Integration Joint Board was formally established on 27 June 2015 and hence the period to 31 March 2016 is its first period of operation. Consequently there are no corresponding amounts for previous years to be shown.

(h) Support Services

Support services were not delegated to the IJB and are provided by the Council and the Health Board free of charge as a "service in kind".

Note 2 – Short Term Debtors

	31 March 2016 £000
Shetland Islands Council	7,747
NHS Shetland	8,554
Total	**16,301**

Note 3 – Short Term Creditors

	31 March 2016 £000
Shetland Islands Council	(7,747)
NHS Shetland	(8,554)
Total	**(16,301)**

Note 4 - Corporate expenditure

	2015/16 £000
Travel & Subsistence	2
Audit Fees	17
Total	**19**

Note 5 - Related party transactions

The Integration Joint Board (IJB) was formally constituted on 27 June 2015 and became live on 20 November 2015 when its Strategic Plan was adopted by Members. In the period from 27 June 2015 to 31 March 2016 the following transactions were made with NHS Shetland and Shetland Islands Council relating to integrated health and social care functions:

Income – payments for integrated functions:

	£000
Shetland Islands Council	(7,756)
NHS Shetland	(8,564)
Total	**(16,320)**

Expenditure – payments for integrated functions:

	£000
Shetland Islands Council	7,756
NH Shetland	8,564
Total	**16,320**

Note 6 - Post Balance Sheet Events

The unaudited Annual Accounts were authorised for issue on 28 June 2016 at the meeting of the IJB. Where events which took place before this date provided information about conditions which existed at 31 March 2016, the Annual Accounts and notes have been adjusted in all material respects to reflect the impact of this information. Events taking place after this date have not been reflected in the Annual Accounts and notes.

Note 7 – Contingent assets and liabilities

A review of potential contingent assets and liabilities has been undertaken for the IJB and none have been identified at 31 March 2016.

Audit Opinion

Agenda Item

2

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	28 June 2016
Report Title:	2016-17 Budget
Reference Number:	CC-46-16 F
Author / Job Title:	IJB Chief Financial Officer

Decisions / Action required:

The IJB is asked to:

1 Note the proposals with regard to the IJB budget allocations for 2016/17 as set out in this report.

2 Note the indicative IJB budget allocations for 2017/18 and 2018/19.

High Level Summary:

1 The purpose of this report is to present to the Integration Joint Board (IJB) the flow of funding to and from the IJB and the controllable budget proposals for the services within its remit.

2 The budget detailed in this report is mirrored in the Strategic Commissioning Plan 2016/17 which is the subject of a separate report on today's agenda. This report provides more detail behind the budget setting process and the final IJB budget for 2016/17. The report also includes indicative IJB budgets for 2017/18 and 2018/19 which are subject to change during future budget setting cycles.

Corporate Priorities and Strategic Aims:

The proposals support the IJB's vision, aims and strategic objectives as set out in the Integration Scheme and the Strategic Plan 2016-19, which is the subject of a separate report. However the report recognises that there is currently a lot of work to do in order to close the budget gap in the proposals for the allocation of funds from NHSS. Further reports will be required to inform and seek decisions from the IJB with regard to any changes that may be proposed to services and the Strategic Plan in order to close the budget gap.

Key Issues:

Members of the IJB are asked to note that the resultant gap (£1.777m) between expenditure and income for NHSS means that options to balance the budget will need to include the consideration of reductions in service budgets across all service areas and that the very low growth for NHSS now and anticipated in future years means that this is likely to have an impact on the final value of funding distributed to the IJB during the three

years covered by the Strategic Plan 2016-19. The IJB Chief Officer will continue to be fully involved in the discussions with senior colleagues in NHSS through NHS Executive Management Team (EMT) and will present any detailed proposals with regard to savings in the IJB budget allocation for consideration by the IJB at future meetings together with any changes required to the information in the Strategic Plan 2016-19.

Implications :	
Service Users, Patients and Communities:	Consultation and communication with relevant groups and individuals as appropriate to the proposals have been considered as part of this report, including the development of the Older Peoples Strategy; the Dementia Strategy; and the Strategic Plan 2016-19 for the Integration Joint Board. Changes to NHS budgets will occur as efficiency schemes are developed between now and the end of March 2017. Service change will require a separate process for public and user engagement in line with NHSS, SIC and IJB policies.
Human Resources and Organisational Development:	Any service development proposals or changes affecting staff will be subject to full staff engagement and consultation with staff and their representatives through the Joint Staff Forum and other consultation committees in line with the relevant agencies policies and procedure and reported through the relevant agenda management processes.
Equality, Diversity and Human Rights:	None arising directly from this report. Any equalities impacts will be assessed and considered as part of any proposals for change and schemes for efficiency savings. Budget proposals for SIC have been impact assessed at a high level.
Partnership Working	The Budget in this report will support partnership working across the Health and Social Care Partnership and include budget proposals for integrated services.
Legal:	The proposals in this report are consistent with the Public Bodies Act and the Integration Scheme for Shetland's IJB.
Finance:	This report presents the agreed IJB budget allocations from NHSS and SIC for 2016/17 and indicative figures for 2017-18 and 2018-19, with the detail contained in the report attached. Budgets have been set in line with the proposed Strategic Commissioning Plan 2016/17 which is the subject of a separate report on today's agenda. Efficiencies are required within NHSS arm of the budgets and a Recovery Plan has been developed to ensure there are sufficient resources to deliver the services detailed in the Strategic Commissioning Plan.
Assets and Property:	<u>SIC</u> A risk based approach will be taken for the management of

	property assets to minimise the deterioration and potential failure of assets over the life of the Medium Term Financial Plan. Where possible unused assets will be disposed of to reduce ongoing revenue costs and maximise capital receipts for the Council. NHS The Board has developed a ten year asset replacement schedule, based on indicative capital allocations from the Scottish Government, which will minimise the deterioration and potential failure of assets. Where possible unused assets will be disposed of to reduce ongoing revenue costs and maximise capital receipts for the NHS. IJB Any service developments that have implications for accommodation will be considered by the IJB before being presented to the Council and NHS who retain control and responsibility for the management of the capital programmes and assets.
Environmental:	None arising directly from this report.
Risk Management:	SIC Any failure to meet the reductions in overall budget spending levels will result in the SIC using its reserves unsustainably. The main specific financial risks for the services in this Committee area are: • increased demand for care services as a result of the changing demographics of Shetland's population; • unexpected demand for care services which may be costly depending on the circumstances; • the level of charging income received can vary significantly, as it is dependent on the individual financial circumstances of those in care at any time. These risks are mitigated by the Directorates using a realistic approach and the latest data when setting the budget, and the inclusion in the overall SIC budget of a corporate contingency budget to support cost pressures which may arise during the year. The SIC also has a strong balance sheet and available usable reserves which ensures that the SIC is prepared for significant unforeseen events. Any draw on reserves beyond the SIC's sustainable level would have an adverse impact on the level of returns from the SIC's long-term investments and this situation would require to be addressed quickly to ensure no long term erosion of the investments. NHS Any failure to meet the reductions in overall budget spending levels will result in the NHS using under spends, as a result of both recurrent and non recurrent efficiency schemes, from other

	directorates to underwrite the position. The main specific financial risks for the integrated services are: • increased demand for care services as a result of the changing demographics of Shetland's population; • GP Prescribing inflation; • Staff recruitment and retention issues resulting in the use of high cost locums. These risks are mitigated by the Directorates using a realistic approach and the latest data when setting the budget, and the inclusion in the overall NHS budget of a general contingency reserve to support cost pressures which may arise during the year. <u>IJB</u> The main risks for the IJB are that the funding allocations from the SIC and NHSS for the functions delegated to the IJB are insufficient to deliver the outcomes set out in the Strategic Plan. The IJB is required to assess these risks and advise the partners accordingly.

Policy and Delegated Authority:	The IJB has delegated authority from the SIC and NHSS for the functions covered by the budget allocations presented in this report. The budget allocations of each of the partners will be set by the SIC and NHSS and thereafter, the IJB must direct service delivery within the budget allocation informing the partners of any issues with regard to the budget allocations. With regard to the deficit in the NHS budget allocation, the IJB will be required to approve a Recovery Plan.
Previously considered by:	The proposals in this report have not been presented to any other committee or organisation.

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	28 June 2016
Report Title:	2016/17 Budget
Reference Number:	CC-46-16 F
Author / Job Title:	Karl Williamson / Chief Financial Officer

1. Introduction

1.1 The purpose of this report is to present to the Integration Joint Board (IJB) the flow of funding to and from the IJB and the controllable budget proposals for the services within its remit.

1.2 The budget detailed in this report is also included in the Strategic Commissioning Plan 2016-19 which is to be presented to the IJB at today's meeting (28th June 2016) for approval. This report provides more detail behind the budget setting process and the final IJB budget for 2016/17.

2. Background

2.1 The IJB was presented with a draft budget on 29th February 2016. It was stated at that time the NHS Shetland (NHSS) part of the budget would be subject to change until finalised by the Scottish Government on 30th June 2016.

2.2 NHSS has now received clarity on their 2016/17 financial allocations and the NHSS Strategy & Redesign Committee agreed the final budget on 23rd May 2016.

2.3 NHSS has been advised of a deduction in non-core baseline funding averaging 7.5% in total. However some services such as Keep Well and Drug and Alcohol Funding have been reduced significantly more than this average value at 71.5% and 18% respectively. Offsetting these other allocations such as the Mental Health non-core and Primary Care non-core funds had no deduction applied to them. There was also an increase to the pay award for staff earning below £22k.

2.4 The Shetland Island Council (SIC) budget has not changed from the version presented to the IJB on 29th February 2016.

3. 2016/17 Budget

3.1 The 2016/17 budget for the services the IJB has responsibility for is £42.820m. These services are paid for by contributions from SIC and NHSS. This forms the funding that is available to the IJB and enables it to then distribute funding to ensure the delivery of services in accordance with its Strategic Plan.

3.2 The funding that is anticipated from each organisation has been advised as follows:

	SIC	NHSS	NHSS Set Aside	Total
	£,000	**£'000**	**£'000**	**£,000**
Core Funding	19,920	17,741	3,725	**41,386**
Integrated Care Funding	-	410	-	**410**
Social Care Funding	-	1,024	-	**1,024**
Total	**19,920**	**19,175**	**3,725**	**42,820**

3.3 This provides the IJB with a total funding allocation of £42.820m with which to direct service delivery through SIC and NHSS.

3.4 The Integrated Care Funding of £0.410m received by NHSS is now included recurrently in the baseline core funding. The budget on 16 December announced a new £250m fund for Social Care Funding. The allocation to NHSS is £1.024m for Adult Social Care outcomes. Scottish Government has issued guidelines on the use of these funds.

3.5 The proposed distribution of the funding allocation for the IJB has been prepared by taking account of the costs associated with delivering the current services, the service challenges and cost pressures that require to be accommodated during the year and emerging guidance from Scottish Government with regard to the Integration Funding streams.

3.6 The total anticipated cost of service delivery is £44.597m, which means there is a shortfall in funding of £1.777m in the IJB budget for 2016/17. This is due to the inclusion of the NHSS efficiency target for the IJB which is explained in paragraph 3.15 below.

	2016/17 IJB Budget		
Service	**SIC £'000**	**NHSS £'000**	**NHSS Set Aside £'000**
Mental Health	1,060	1,353	-
Substance Misuse	257	496	-
Oral Health	-	3,123	-
Pharmacy & Prescribing	-	5,714	462
Primary Care	-	4,571	-

Community Nursing	-	2,330	-
Directorate	259	94	-
Pensioners	78	-	-
Sexual Health	-	-	38
Adult Services	5,201	66	-
Adult Social Work	1,665	-	-
Community Care Resources	10,512	-	-
Criminal Justice	29	-	-
Speech & Language Therapy	-	83	-
Dietetics	-	112	-
Podiatry	-	225	-
Orthotics	-	143	-
Physiotherapy	-	603	-
Occupational Therapy	1,371	185	-
Health Improvement	-	-	310
Unscheduled Care	-	-	3,190
Renal	-	-	145
Total	**20,432**	**19,098**	**4,145**
Scottish Government Additionality Funding for Adult Social Care (see paragraph 3.7)	512	-	-
Integrated Care Funding (see paragraph 3.9)	-	410	-
Total	**20,944**	**19,508**	**4,145**
Grand Total	**44,597**		

3.7 The £0.512m Scottish Government Additionality Funding for Adult Social Care in the table above represents 50% of the £1.024m received by NHSS as a result of the additional £250m funding announced nationally for Adult Social Care outcomes, which is being paid to NHS boards. This funding is to be made available for the delivery of additional adult social care services and outcomes in order to address the rising demand for services from an ageing population.

3.8 The remainder of the £1.024m additional integration funding has been recognised by SIC as funding to support the cost of current service delivery, i.e. to pay for cost increases and the living wage applying to all adult social care service providers. This use of the additional funding allocation is in line with emerging guidance from Scottish Government.

3.9 The Integrated Care Funding of £0.410m has not yet been allocated to service delivery and is the subject of a separate report to the IJB.

3.10 Further information regarding the approach taken by SIC and NHSS to preparing the budget allocation proposals for the IJB is provided in the remainder of this section of the report.

SIC Budget Allocation for the IJB

3.11 The Council's Corporate Management Team (CMT) reviewed the budget proposed to the Policy and Resources Committee in November 2015 and in addition to the savings plans proposed at that time looked at how to meet the additional savings target of £2.6m caused by the reduction in the allocation of funding from the Scottish Government.

3.12 The Director of Community Health and Social Care (CH&SC) is a member of CMT and was fully involved in this process. During the review, £512k of costs were identified immediately within the SIC budget for 2016/17 that met the criteria for the additional Scottish Government funding (Para 3.8 above). Therefore the budget recommendations for 2016/17 which were approved by the Council on 10 February 2016 took full value of this funding into account in determining the Council's budget and its allocation for the IJB.

3.13 Other proposals to meet the £2.6m funding gap did not affect the IJB directly apart from a non recurrent savings target to recognise a vacancy factor (£0.166m).
There is a proposal to reduce the budget for adaptations through the scheme administered by Infrastructure Services, however, this is based on historical spending patterns and will not mean that any applications that meet the criteria will be refused or delayed as there will be provision made in the Council's contingencies.

3.14 The SIC budget allocation for the IJB is summarised in the table at paragraph 3.6 above. This is a balanced budget and the budget allocation is reflected in the Strategic Plan 2016-19, which is the subject of a separate report.

NHS Shetland Budget Allocation for the IJB

3.15 The difference between funding and service expenditure for the IJB as set out in this report is explained by the shortfall between how much the NHSS services are costing and the core funding that is available from NHSS. Finding savings to resolve this imbalance is therefore essential to the balancing of the budget in the coming year. The NHSS efficiency target proposed for the IJB is made up of:

	NHSS £'000	**NHSS Set Aside £'000**
CH&SC 2015/16 unachieved recurring target b/f	747	171
CH&SC 2016/17 target	368	124
CH&SC Additional 2016/17 target	241	125
Total	**1,357**	**420**

The £420k target for the 'set aside' budget is a notional 26% of the overall target for the Directorate of Acute & Specialist Services.

For directly managed services the reduction in the bundled allocations has been reflected in the budget allocated to services.

3.16 Members of the IJB are asked to note that the resultant gap between expenditure and income for NHSS means that options to balance the budget will need to include the consideration of reductions in service budgets across all service areas and that the very low growth for NHSS now and anticipated in future years means that this is likely to have an impact on the final value of funding distributed to the IJB during the three years covered by the Strategic Plan 2016-19. The IJB Chief Officer will continue to be fully involved in the discussions with senior colleagues in NHSS through NHS Executive Management Team (EMT) and will present any detailed proposals with regard to savings in the IJB budget allocation for consideration by the IJB in due course together with any changes required to the information and proposals in the Strategic Plan 2016-19.

3.17 A Recovery Plan has been developed to address the NHSS shortfall and will be presented to the IJB as a separate report.

Overall IJB Budget Summary

3.17 Reconciling the differences between the funding and service delivery can be shown as follows.

	SIC £'000	**NHSS £'000**	**NHSS Set Aside £'000**	**Total £'000**
Funding Received from	(19,920)	(19,175)	(3,725)	**(42,820)**
Funding Distributed to	20,944	18,151	3,725	**42,820**
Inter body Movement of Resources	**1,024**	**(1,024)**	**0**	**0**
Indicative cost of Core Services	20,432	19,508	4,145	**44,085**
Funding held for Additionality	512		-	**512**
Efficiency Targets to meet funding	-	(1,357)	(420)	**(1,777)**
	20,944	**18,151**	**3,725**	**42,820**

3.18 The table above shows the shift in resources to ensure that the full value of £1.024m that has been made available through NHSS is used / allocated for the purposes of adult social care services. In-line with the Scottish Government letter to COSLA SIC is offsetting 50% of these costs £512k against prior investments.

Next steps

3.19 The 2016/17 budget will be approved by the IJB as part of the Strategic Commissioning Plan 2016-19 process.

3.20 There is also an indicative 2017/18 and 2018/19 budget included in the Strategic Commissioning Plan as required by the IRAG guidance. These indicative future budgets are subject to annual approval through the respective budget setting processes. Appendix 1 details the three year indicative budget of the IJB.

3.21 The level of detail in Shetland's Strategic Plan will comprise all the information required in the Directions from Shetland's IJB to the Council and the Health Board. It is therefore proposed that, following approval of the final version of the Strategic Plan and any subsequent revision, the IJB writes formally to the Council and the Health Board directing the Council and the Health Board to carry out the actions allocated to them in the Strategic Plan and formally stating that this constitutes the Directions to the Council and the Health Board as required by statute and in line with the Good Practice Note.

3.22 Quarterly Management Accounts will be presented to the IJB to allow members to understand the in year financial performance against the agreed Strategic Commissioning Plan.

4. Recommendations

The IJB is asked to:

4.1 Note the proposals with regard to the IJB budget allocations for 2016/17 as set out in this report.

4.2 Note the indicative IJB budget allocations for 2017/18 and 2018/19.

Contact Details:
For further information please contact:
Karl Williamson, NHS Head of Finance & Procurement / IJB Chief Financial Officer
karlwilliamson@nhs.net Tel 01595 743301
02nd June 2016

Appendices
Appendix 1 - IJB three year indicative budget allocation

Appendix 1

Service	2016/17 Budget			2017/ 2018 Indicative Budget			2018/ 2019 Indicative Budget		
	SIC	NHSS	NHSS Set Aside	SIC	NHSS	NHSS Set Aside	SIC	NHSS	NHSS Set Aside
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Mental Health	1,060	1,353	-	1,060	1,353	-	1,060	1,353	-
Substance Misuse	257	496	-	257	496	-	257	496	-
Oral Health	-	3,123	-	-	3,123	-	-	3,123	-
Pharmacy & Prescribing	-	5,714	462	-	5,714	462	-	5,714	462
Primary Care	-	4,571	-	-	4,571	-	-	4,571	-
Community Nursing	-	2,330	-	-	2,330	-	-	2,330	-
Directorate	259	94	-	259	94	-	259	94	-
Pensioners	78	-	-	78	-	-	78	-	-
Sexual Health	-	-	38	-	-	38	-	-	38
Adult Services	5,201	66	-	5,201	66	-	5,201	66	-
Adult Social Work	1,665	-	-	1,665	-	-	1,665	-	-
Community Care Resources	10,512	-	-	10,512	-	-	10,512	-	-
Criminal Justice	29	-	-	29	-	-	29	-	-
Speech & Language Therapy	-	83	-	-	83	-	-	83	-
Dietetics	-	112	-	-	112	-	-	112	-
Podiatry	-	225	-	-	225	-	-	225	-
Orthotics	-	143	-	-	143	-	-	143	-
Physiotherapy	-	603	-	-	603	-	-	603	-
Occupational Therapy	1,371	185	-	1,371	185	-	1,371	185	-
Health Improvement	-	-	310	-	-	310	-	-	310
Unscheduled Care	-	-	3,190	-	-	3,190	-	-	3,190
Renal	-	-	145	-	-	145	-	-	145
Total	**20,432**	**19,098**	**4,145**	**20,432**	**19,098**	**4,145**	**20,432**	**19,098**	**4,145**
Scottish Government Additionality Funding for Adult Social Care	512	-	-	512	-	-	512	-	-
Integrated Care Funding	-	410	-	-	410	-	-	410	-
NHSS Efficiency Target	-	-1,357	-420	-	-2,083	-569	-	-2,780	-712
Total	**20,944**	**18,151**	**3,725**	**20,944**	**17,425**	**3,576**	**20,944**	**16,728**	**3,433**
Grand Total		**42,820**			**41,945**			**41,105**	
Total 3 Year Indicative budget allocation	**125,870**								

Agenda Item

3

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	28 June 2016
Report Title:	Financial Recovery Plan 2016/17 - *Cover*
Reference Number:	CC-42-16 F
Author / Job Title:	Simon Bokor-Ingram, Director Community Health & Social Care

Decisions / Action required:

The Integration Joint Board is asked to note:

- The progress and the work that is in hand on the Financial Recovery Plan and the actions being taken and planned for.
- Further reports will be brought to subsequent IJB meetings with more detail on specific projects where a decision is required.
- Update reports on progress against the overall savings target will be brought on a regular basis to the IJB

High Level Summary:

The Financial Recovery Plan sets out the anticipated financial pressures for the IJB which relate to pressures within the NHSS budgets for directly managed and set aside services for 2016/17. The IJB budget is made up of two allocations. The SIC budget is balanced. NHS Shetland (NHSS) budget has a financial gap where savings need to be generated. Based on current information, there is a combined gap of £1.777M in the directly managed and set aside budget for NHSS, and this is the focus of the recovery plan.

Corporate Priorities and Strategic Aims:

In order to fulfil the statutory duties with regard to the functions delegated to the IJB by the SIC and NHSS, the IJB must consider and address the challenges and risks of planning for and directing the provision of services. The IJB will aspire to deliver on the Strategic Plan but this will need to take into account the available resources. The financial gap for 2016/17 in the NHSS allocation will need to be addressed through a planning process involving service redesign.

Key Issues:

This recovery plan is being presented because it is evident that the savings schemes for the NHSS budget allocation will not deliver the full year effect, and there is a risk of a gap between the savings expected and the schemes that are being generated.

Implications :	
Service Users, Patients and	Any significant service changes as a result of the shortfall in the NHSS allocation will need a separate process for public and

Communities:	user engagement, and a change to the Strategic Plan.
Human Resources and Organisational Development:	Where there is a need for service change, this may potentially have an impact on staff, and will be planned and delivered in partnership with staff and through due process. This would involve engagement with the Joint Staff Forum and with other consultative forums. The challenge of the vacancy factor generating £166k saving in social care will be carefully monitored to ensure that existing staff are well supported and to avoid an impact on individuals and service delivery.
Equality, Diversity and Human Rights:	No equalities issues have been identified to date. An impact assessment will be undertaken for any redesign of how we deliver services.
Partnership Working	There are well established processes in place to engage with the public; third sector and other statutory agencies. There are established forums for engagement with unions and staff. The Strategic Planning Group which reports to the IJB brings together key stakeholders and this group would advise the IJB on changes to the Strategic Plan.
Legal:	Under the terms of the Public Bodies (Joint Working) (Scotland) Act 2014, the IJB is responsible for the strategic planning of the functions delegated to it by the SIC and NHSS and for the preparation of the Strategic Plan. The Strategic Plan specifies the services to be delivered by the parties. Where there is a forecast overspend against an element of the operational budget then a recovery plan shall be subject to the approval of the IJB.
Finance:	The NHSS has a statutory responsibility each year to reach an in-year break even position on its finance. Up until now NHSS has achieved this each year. Should a year end deficit become likely in 2016/17, NHSS will need to begin discussions with the Scottish Government Health and Social Care Directorate. Any year-end deficit will put further pressure on budgets in following years.
Assets and Property:	There are no implications for major assets and property i.e. buildings and equipment at this stage. Any proposals identified through service redesign will be presented to the IJB. Assets and property remain the respective property of the SIC and NHSS.
Environmental:	There are no implications for the local environment and a Strategic Environmental Impact Assessment is not required.
Risk Management:	The IJB has agreed a Risk Management Strategy and Risk Register which includes risks associated with the delivery of the Strategic Plan. Key risks relate to failure to deliver service change including the achievement of recurring savings within some services. Savings schemes are being developed to cover the financial gap in the NHSS allocation. The risks around staff recruitment and retention in social care are being carefully managed, with staff overtime reducing significantly in Q4 in 2015/16.

Policy and Delegated Authority:	Shetland's Integration Joint Board has delegated authority to determine matters relating to those services for which it has responsibly and oversight for, as set out in the Integration

	Scheme and the IJB Scheme of Administration [2015]. In exercising its functions the IJB must take into account the requirement to meet statutory obligations placed on the NHS and SIC, including those that pertain to delegated IJB functions.
Previously considered by:	This report has not been presented at any formal meeting.

Shetland Islands Council

Meeting:	Integration Joint Board
Date:	28 June 2016
Report Title:	Financial Recovery Plan 2016/17
Reference Number:	CC-42-16 F
Author / Job Title:	Simon Bokor-Ingram, Director Community Health and Social Care

1. Introduction

1.1 The budget setting process for 2016/17 has identified that there is a financial challenge for the IJB in the NHS Shetland (NHSS) budget, where savings of £1.777M in total for directly managed services and the set aside are required to be generated in order for NHSS to be able to balance its overall budget. The savings that are required amount to 8% of the total NHSS allocation.

1.2 There is a requirement to develop a recovery plan for the IJB. The Shetland Islands Council (SIC) budget is balanced and so this recovery plan focuses entirely on NHSS budgets. A recovery plan for 16/17 was presented to the IJB on the 29th February 2016. The plan has now been updated, with the budget for NHSS now agreed by the NHSS Board.

1.3 Both Community Health and Social Care, and Acute and Specialist Services, will be expected to deal with any in-year cost pressures before seeking further financial support from either the SIC or the NHSS, depending on which organisation is funding the particular service where the cost pressure has arisen.

For 2016/17, an efficiency target has been given to the Social Care budget, of £166,000, as a non-recurrent sum to be generated by vacancies. This will be achieved through the vacancy factor generated between people leaving the service and new recruits starting. The SIC part of the Directorate budget is balanced and information has previously been reported and agreed by IJB members.

1.4 For NHSS, efficiency schemes have been identified which will need to deliver in-year in 2016/17. For the NHSS allocation to the IJB a number of these schemes will not deliver from the 1 April 2016. This has been factored into the NHSS financial plan for 16/17, however, overall this means that NHSS will continue to rely significantly on non-recurrent savings if it is to achieve a break-even position at year end.

1.5 The Shetland Islands Health & Social Care Partnership Scheme of Integration is clear on how financial pressures must be dealt with:

"Where there is a forecast overspend against an element of the operational budget, the Chief Officer, the Chief Finance Officer of the Integration Joint Board will work with the LPFT [Local Partnership Finance Team] and the appropriate finance officers of the Parties to agree a recovery plan to balance the overspending budget. The recovery plan shall be subject to the approval of the IJB.

If the recovery plan is not successful the Chief Officer and the Chief Financial Officer will work with the LPFT to develop options to address the overspend which may include the option of making interim funds available with repayment in future years on the basis of a revised recovery plan agreed by the Parties and the IJB."

1.6 This recovery plan has been developed because it is evident that the savings schemes for NHSS budgets will not deliver the full year effect in every case, and there is a gap between the savings required to achieve balance and the schemes that are being generated.

2. Background

2.1 The Scottish Government financial strategy has required NHS Scotland to achieve year on year recurring efficiency savings of around three percent. The funds released from the achievement of efficiencies are retained locally to address local cost pressures, demographic pressures, new drug costs and to deal with the impact of inflation.

2.2 The current NHSS efficiency savings plan was set to cover the five years from 2012/13 to 2016/17. That plan sets NHSS Corporate and Support Services an ambitious efficiency saving target over the five years that was equivalent to 25% of their 2011/12 baseline budgets. The balance of the efficiency targets was assigned to Clinical Services, which at that time consisted of a single directorate. Clinical Services was subsequently divided into two directorates - Acute and Specialist Services and Community Health and Social Care. The combined target for clinical services required achievement of £4.1 million efficiencies over the five year period. At the end of 2014/15, the first three years, £1.8m of the clinical efficiency target had been realised.

2.3 Both Acute and Specialist Services and Community Health have the added amount of their respective unachieved savings target from previous years in the savings target for 2016/17.

2.5 Appendix 1 outlines the current position in respect of the savings target for both directly managed services and the set aside budget, with unachieved savings to be carried forward, the savings target for next year, and the total accumulated target for 2016/17.

2.6 Detailed plans are in development that describe how savings projects will be taken forward; timescales; and the phasing in of savings during the year. Risks will be described, and aggregated for the Directorate and IJB Risk Registers where those risks cannot be managed at a service level. Appendix 2 sets out the project areas with the expected timescales for implementation.

2.7 In year for 2016/17 the potential for a budget over spend has been recognised by NHSS and where possible efforts will be made to limit spend. Whilst non-recurrent savings will contribute to the budget, this is not a sustainable long term solution. In the short term, limiting discretionary spends; delaying recruitment and using vacancies that arise as an opportunity to redesign delivery need to be implemented.

2.8 NHSS experienced a very challenging year in 2015/16. Break-even was reached because of non-recurrent savings being generated. Should a year end deficit become likely in 16/17, NHSS will need to begin discussions with the Scottish Government Health and Social Care Directorate.

3. Impacts

3.1 The NHSS has a statutory responsibility each year to reach an in-year break even position on its finances. Up until now NHSS has achieved this each year.

3.2 At present there are a number of factors which are putting pressure on budgets. Whilst there has been much work carried out to redesign services over the years, redesign has not kept pace with the underlying pressure on the NHSS budget. Non recurrent funding has been used in increasing amounts in the last few years to balance the overall budget at year end.

3.3 Non-recurrent savings will need to be identified not just within directly managed services and the set aside but also across NHSS to support an in-year break even position for 2016/17, particularly as the savings schemes set out in Appendix 2 will not deliver full year effect in many

cases. If those actions are not adequate to meet the predicted financial gap, and a year-end deficit is likely, then NHSS would need to begin discussions with the Scottish Government Health and Social Care Directorate.

3.4 There will need to be a continued focus on budget positions and the efficiency and redesign agenda. Services will need to consider all opportunities in-year to generate further non-recurrent savings; control discretionary expenditure levels; and to plan for schemes beyond 2016/17 that will restore recurrent financial balance and the detail will be reported to the IJB.

3.5 There will need for an ongoing IJB programme of work to develop detailed savings schemes, with clear timeframes, that will create sustainability for 2016/17 and beyond. This will need to be done in conjunction with the work being undertaken by NHSS to meet the same objectives. Part of the IJB's consideration in making decisions will need to be the balance between quality, cost and time.

4. Conclusions

4.1 With such a focus on finances, it is important that the commitment to safety and quality in delivering care is maintained, and the full governance structure of NHSS is used to ensure that. The Joint Clinical Care and Professional Governance Committee for NHSS, SIC and the IJB has recently been established and this Committee will be key to ensuring safety and quality. At the same time, it is imperative that the services operate within the available resources allocated to them.

4.2 Monitoring and reporting maintains the audit trail of where spend is made against budget for both SIC and the NHSS, and delineates between each organisations budget and expenditure.

4.3 Whilst the task ahead is going to be very challenging, NHSS has a long history of delivering within its financial budget each year. The NHSS is fully committed to creating a sustainable position for the long term. The Executive Management Team of NHSS are currently refining the efficiency programme for 2016/17.

4.4 Reports on individual efficiency projects will be brought to the IJB for a decision when the project has reached that stage, with the relevant section of the Strategic Plan describing the service change, the impact and risks.

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9 June 2016

Appendices:
Appendix 1 - Current position in respect of the savings target for both Services
Appendix 2 - NHSS Savings Schemes 2016/17

2016/17 Savings Requirement Feb 2016

	IJB 'Set Aside'	IJB Joint Budgets	Total	NHS Total
	£000s	£000s	£000s	£000s
Unachieved recurring savings brought forward	171	747	919	1,462
2016-17 Savings Target	124	368	492	1,194
Additional savings required as a result of agreed cost pressures	30	241	271	654
Additional savings required as a result of 7.5% reduction in 'bundled' allocations	95	0	95	146
Total	420	1,357	1,777	3,456
Savings as a percentage of overall funding for IJB Services	10.9%	7.3%	8.0%	

Set Aside figures above are 26% of total Acute Services Directorate efficiency target

NOTE: The Savings target relate solely to the NHS Shetland part of the IJB Budgets

DIRECTLY MANAGED SERVICES

Community Health & Social Care

Project	Estimated Full Year Effect £	Achievable in 2016/17	By When	Detail	Risks
Primary Care Management Costs	25,000	12,500	Aug-16	Review of health centre management. Opportunity to incorporate clinical leadership into the management model. Reallocation of roles and responsibilities has potential efficiency saving.	Reduction in capacity. Arrangement will need careful monitoring to ensure effiacacy.
Lerwick Health Centre costs	75,000	37,500	Aug-17	The ANP model is now in place. Patient list number has fallen. Activity and capacity being reviewed with potential for efficiency. Focus on promoting self-management to support demand management. Dedicated Pharmacist time supporting the practice.	Demand for service continues at current rate, or increases. Continued confidence in ANP model.
OOH Vehicle configuration	10,000	9,000	Apr-16	2nd out of hours vehicle in place to reduce need for moving single asset to next on call clinician.	2nd vehicle in place and efficiency being generated.
Community Nursing capacity to match demand	240,000	63,000	Mar-17	Full review of capacity and demand across Shetland of the Community Nursing Service. Will include options for extending out of hours provision and advanced practice. Support to communities to build capacity through initiatives including First Responder scheme promoted by Scottish Ambulance Service.	Communities not engaging with plans for future service delivery.
Pharmacy Challenge	200,000	200,000	Mar-17	Prescribing initiatives commenced. Pharmacists supporting practices with efficient prescribing. Number of work streams initiated. Local benchmarking programme in place.	Prescribing costs continue to increase, and above national trends. Pharmacists unable to engage clinicians in programmes.
Primary Care Redesign	200,000	30,000	Mar-17	Implementation of Primary Care Strategy. Options need to be developed to create resilience and sustainability. Project support for primary care being sought.	Unable to engage local clinicians. Communities not engaging with plans for future service delivery.
Off Island Mental Health Activity	44,630	44,630	Apr-16	More responsive local service that results in less people having to go off-island for in-patient mental health provision. Local service developing out of hours crises response.	Local service's ability to meet complex needs. Ability to respond out of hours to acute presentations.
Non recurrent savings	100,000	100,000	Mar-17	Seeking all opportunities to create efficiency, through pay and non pay budgets. Continuing to seek opportunities for redesign of services, through national benchmarking and work-streams.	Prolonged vacancy factor could affect capacity of services. Reducing non pay expenditure may build pressure for future years.
TOTAL	**894,630**	**496,630**			

ACUTE & SPECIALIST SERVICES

Acute & Specialist Services

Projects	Estimated Full Year Effect £	Achievable in 2016/17	By When	Detail	Risks
Acute services redesign	475,000	203,000	Mar-17	Match hospital capacity to demand for bed base. Incorporate factors including shifting balance of care; reduced delayed discharges and shortening lengths of stay.	Ability of community services to build capacity. Maintaining low rates of delayed discharges.
Increasing the use of telehealth and redesigning patient pathways	250,000	250,000	Mar-17	Repatriation of services to Shetland, resulting in less spend on off island activity and less spend on patient travel.	Ability to engage NHS Grampian in shifting care to Shetland. Confidence of clinicians to utilise and increase technology enabled care provision.
Hospital management team restructuring	20,000	20,000	Mar-17	Redesigning job roles and aligning capacity to service need.	Ability to recruit to posts.
Non recurrent savings	300,000	300,000	Mar-17	Seeking all opportunities to create efficiency, through pay and non pay budgets.	Prolonged vacancy factor could affect capacity of services. Reducing non pay expenditure may build pressure for future years.
TOTAL	**1,045,000**	**773,000**			

26% of acute budget assigned to IJB Set Aside

Agenda Item

4

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	28 June 2016
Report Title:	Joint Strategic (Commissioning Plan) 2016-2019 Cover Paper
Reference Number:	CC-41-16 F
Author / Job Title:	Simon Bokor-Ingram / Director Community Health & Social Care

Decisions / Action required:

The Integration Joint Board is asked to approve the updated Joint Strategic (Commissioning Plan) 2016–2019, recognising that in light of the evolving financial position any revisions will be developed and be brought back to the IJB for further consideration.

Directing the delivery of services by NHS Shetland and Shetland Islands Council as detailed in the Joint Strategic (Commissioning) Plan 2016-19.

High Level Summary:

The Joint Strategic (Commissioning) Plan 2016-19 (referred to as the Strategic Plan) has been developed and updated in consultation with stakeholders and is now presented for approval. It sets out how resources are to be used to deliver through integrated services; how services will contribute to improving people's lives, health and wellbeing; and plans for change to improve the health and wellbeing of people in Shetland, as measured through national and local outcomes.

Corporate Priorities and Strategic Aims:

The Plan sets out how the Integration Joint Board and integrated services will deliver on the National Health and Wellbeing Outcomes (as detailed in the Strategic Plan).

Key Issues:

Consultation on the updated plan has been undertaken in line with the IJB's Participation and Engagement Strategy. It has been considered by the Strategic Planning Group before being presented to the IJB.

The Strategic Plan has been developed to focus more on plans for change and on achieving specific outcomes.

Further development work will continue through the lifetime of the plan in areas such as

locality planning, including budget setting at locality level; and in developing the process of joint commissioning.	
Implications :	
Service Users, Patients and Communities:	The Strategic Plan is intended to bring about improvements in the health and wellbeing of service users and the Shetland community. It is also written to describe service change and should detail any expected impacts on users. Any significant service change would need a separate process for public and user engagement in line with NHS, SIC and IJB policies.
Human Resources and Organisational Development:	Service change is likely to have an impact on staff, and will be planned and delivered in partnership with staff and their representatives through due process. Headline workforce change is signalled in individual service sections. Staff recruitment and retention poses a more immediate risk to the delivery of services and strategies to address recruitment and retention are being developed and will continue to develop as part of emerging services.
Equality, Diversity and Human Rights:	Certain sections of the plan deal specifically with some services and client groups relevant to the equality legislation. No equalities issues have been identified to date. An Equality Impact Assessment is attached as an Appendix to the Plan.
Partnership Working	The Plan is written to deliver partnership working across Integrated Services. A range of services and activities in the Plan also support and rely on wider partnership working particularly with third sector partners.
Legal:	The Plan is developed to comply with the requirements of the Health and Social Care Integration Public Bodies (Joint Working) (Scotland) Act 2014, and associated guidance.
Finance:	The Plan describes services commissioned to be delivered within the budgets delegated to the IJB from the Council and Health Board.
Assets and Property:	There are no implications identified to date for major assets and property i.e. buildings and equipment.
Environmental:	There are no implications for the local environment and a Strategic Environmental Impact Assessment is not required.
Risk Management:	The IJB has agreed a Risk Management Strategy and Risk Register which include risks associated with the delivery of the Strategic Plan. Key risks relate to failure to deliver service change including the achievement of recurring savings within some services.

Policy and Delegated Authority:	Shetland's Integration Joint Board has delegated authority to determine matters relating to those services for which it has responsibly and oversight for, as set out in the Integration Scheme and the IJB Scheme of Administration [2015]. In exercising its functions the IJB must take into account the requirement to meet statutory obligations placed on the NHS and SIC, including those that pertain to delegated IJB functions. Having approved the Strategic Plan for 2015/16 the IJB has now assumed responsibility for the functions delegated to it by the Council and the NHS, which includes approval of future updated versions of the Joint Strategic (Commissioning) Plans.

Previously considered by:	Strategic Planning Group	10.06.2016

Shetland Islands Council

Meeting:	Integration Joint Board
Date:	28 June 2016
Report Title:	Joint Strategic (Commissioning) Plan 2016-2019
Reference Number:	CC-41-16 F
Author / Job Title:	Simon Bokor-Ingram, Director Community Health & Social Care

1. Introduction

1.1 This report presents the updated Joint Strategic (Commissioning) Plan 2016-19 to the Integration Joint Board (IJB) for approval. The Joint Strategic (Commissioning) Plan 2016-2019 (known as the Strategic Plan) is attached at Appendix 1.

2. Background

2.1 The Health and Social Care Integration Public Bodies (Joint Working) (Scotland) Act 2014 requires Integration Joint Bodies (in Shetland the Integration Joint Board) to create a Strategic Plan for the integrated functions and budgets within their authority.

2.2 The Shetland Joint Strategic (Commissioning) Plan 2016-2019 has been produced through consultation with various stakeholders and helps develop a more outcomes-focussed approach to strategic commissioning and service planning through joint budget setting.

2.3 Directions from the Integration Authority (IJB) to the Council and the Health Board are required in order to action the IJB's Strategic Plan

2.4 Direction must be given in respect of every function that has been delegated to the IJB, and full details of the functions delegated to the IJB are listed in the Strategic Plan.

3. The Plan

3.1 The Strategic Plan is structured around the client groups/services that are included within the delegated authority of the IJB, with a section on Locality Planning. In addition it includes plans for NHS non-integrated services to provide a single Joint Strategic (Commissioning) Plan for health and social care in Shetland.

3.2 Each section is designed to include a brief outline of relevant policy context and current services, drivers for change including savings targets, needs and unmet needs, plans for change linked to expected outcomes and key risks to delivery. It specifies key actions and priorities for the coming year.

3.3 The Plan includes headline figures on service budgets. The Plan contains the allocated budgets from both the Council and Health Board. The savings target for the Health Board is allocated to the Chief Officer, and will be set against individual service budgets as schemes are developed. A Recovery Plan is the subject of a separate report.

3.4 The Plan also sets out the arrangements for carrying out the integration functions in Shetland over the period of the plan, and refers to development work being undertaken and planned to support the process of joint strategic commissioning.

3.5 The IJB recognises the 7 planning localities as detailed in the Plan. During 2015/16 a round of meetings was held across localities to inform the development of joint commissioning at locality level. More recently the Chief Officer and IJB Voting Members (including the Chair) held locality engagement meetings with staff to gather views and comments on how integration was progressing. A report on the outcomes of these meetings will be presented to the IJB in September.

3.6 The Strategic Planning Group had considered the Strategic Plan before its presentation to the IJB.

3.7 Further development work that has been completed:

- The current CHCP Procurement Strategy was replaced by an updated Joint Commissioning and Procurement Strategy.

- An agreed and transparent option appraisal process, especially to underpin major investment and disinvestment decisions, will be developed, building on an update of the NHS Board's Decision Making Policy and current best practice in both NHS Shetland and Shetland Islands Council.

- A Market Facilitation Plan will be developed in line with national guidance and relevant to the Shetland context.

4. Directions

4.1 The Scottish Government published a Good Practice Note on Directions from Integration Authorities to Health Boards and Local Authorities in March 2016.[1]

4.2 The Guidance Note explains that Directions from the Integration Authority (IJB) to the Council and the Health Board are required in order to action the IJB's Strategic Plan and that a Direction must be given in respect of every function that has been delegated to the IJB. Full details of the functions delegated to the IJB are included in the Integration Scheme http://www.shetland.gov.uk/Health_Social_Care_Integration/documents/SHSCPartnershipIntegrationScheme15May2015.pdf.

4.3 Directions must set out how each integrated health and social care function is to be exercised and the budget associated with that.

4.4 For Shetland, this level of detail is contained in the Strategic Plan. In many other partnership areas, the Strategic Plan is a high level strategic overview whereas Shetland's Strategic Plan incorporates detailed service plan information, how services will be delivered and by whom and the associated budgets.

4.5 Directions must also be revised in year to reflect any changes in how the delegated functions are to be carried out by the Council and the Health Board including any changes to the budget allocations or new service developments. The processes for agreeing changes of this nature are set out in the Integration Scheme. In Shetland, the Strategic Plan is a living document that is kept up to date when any such changes have been approved by the IJB and the Strategic Plan will also be updated annually as service plans and budgets are set for the incoming financial year.

4.6 Locally, work is in hand to develop a recovery plan for the shortfall in the NHS funding allocation for the IJB. Once this is approved, the Strategic Plan will be updated accordingly and reissued to the Council and the Health Board.

4.7 This means that the level of detail in Shetland's Strategic Plan, with the addition of specific references to each delegated function, will comprise all the information required in the Directions from Shetland's IJB to the Council and the Health Board.

[1] http://www.gov.scot/Resource/0049/00498164.pdf

4.8 It is therefore proposed that, following approval of the final version of the Strategic Plan and each subsequent revision, the IJB writes formally to the Council and the Health Board directing the Council and the Health Board to carry out the actions allocated to them in the Strategic Plan and formally stating that this constitutes the Directions to the Council and the Health Board as required by statute and in line with the Good Practice Note.

5. Performance monitoring

4.1 The Strategic plan is monitored through the IJB performance monitoring systems.

6. Recommendation

5.1 The Integration Joint Board is asked to APPROVE the updated Joint Strategic (Commissioning) Plan 2016 -2019.

7. Conclusions

6.1 The strategic planning process will continue to be developed with work to be an ongoing process to refine the plan.

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7 June 2016

Appendices:
Appendix 1: The Joint Strategic (Commissioning) Plan 2016-2019
Appendix 2: 3 Year IJB Indicative Budget

Background Documents:
Strategic Commissioning Plans Guidance issued by Scottish Government
http://www.gov.scot/Resource/0046/00466819.pdf

NHS SHETLAND

SHETLAND ISLANDS COUNCIL

Joint Strategic (Commissioning) Plan 2016-19

Version 7 – June 2016

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1. Introduction

The Joint Strategic (Commissioning) Plan for 2016/19 (known as the Joint Strategic Plan or the Plan) is developed jointly in partnership with stakeholders, for adoption by the Integration Body. It is compliant with Strategic Commissioning Plans Guidance issued by Scottish Government: http://www.scotland.gov.uk/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Implementation/ImplementationGuidance/SCPlans

It is structured around the client groups / services that are included within the delegated authority of the Integration Body. In addition it includes plans for NHS non-integrated services to provide a single Joint Strategic Commissioning Plan for health and social care in Shetland.

The Plan takes account of other local policy directions as outlined in the Shetland Single Outcome Agreement, Shetland NHS Local Delivery Plan, Shetland Islands Council Housing Strategy, Shetland Community Plan and other local corporate plans.

The Joint Strategic Plan is intended to describe how people's lives, health and wellbeing will be improved. This will include decisions about disinvesting in current services in order to reinvest in other services, and redesign of services to meet on-going and changing demand.

In addition, we expect the Plan to increasingly reflect the developing engagement with stakeholders and local communities in Shetland, through Locality Planning and links to Community Planning, professional involvement and user and carer fora (through strategic planning on older people, primary care strategy development etc). The Integration Body's Communication and Engagement Plan sets out more detail of how we will do this.

Guidance sets out the need for Joint Strategic Needs Assessments (JSNAs) to inform the development of the Strategic Plan through the analysis of the needs of local populations. These Needs Assessments will also inform and guide the commissioning of health, wellbeing and social care services. In Shetland the specific strategies that have informed the Strategic Plan (on Carers, Mental Health, Older People, Dementia and Primary Care) include Joint Strategic Needs Assessments, as well as Locality Profiling to inform Locality Planning, and components of Needs Assessments have been included in Service Plans. Again, this will be an area of development in future iterations of the Joint Strategic Plan, taking into account the NHS National Services Scotland (NSS) linked longitudinal health and social care datasets as they become available.

A further area for future development is on performance monitoring, and developing the key performance indicators already in place to show progress towards meeting the national health and wellbeing outcome indicators.

During 2016/17 we will produce locality plans for Shetland to inform the first year update of this Strategic Commissioning Plan. Each locality plan should include:

- A list of all the services under the management of the Integration Authority of which the locality is a part;
- A note of priorities for each locality under each of the service headings; and
- Planned expenditure under each service heading, using locality budgets.

Financial analysis of service delivery and change will also be developed over the coming year to support analytical processes such as programme budgeting / marginal analysis, and budgeting for locality plans to show how the Integration Authority's resources are currently used by the locality population. In future this historic share should be set alongside a "fair" share target, based on locality populations weighted to take account of population need and any factors relating to provision of service in the area.

Framework for the Shetland Joint Strategic Commissioning Plan

Principles

The integration **delivery principles** are:

- that the main purpose of services which are provided to meet integration functions is to improve the wellbeing of service-users,
- that, in so far as consistent with the main purpose, those services should be provided in a way which, so far as possible:
    - is integrated from the point of view of service-users
    - takes account of the particular needs of different service-users
    - takes account of the particular needs of service-users in different parts of the area in which the service is being provided
    - takes account of the particular characteristics and circumstances of different service-users
    - respects the rights of service-users
    - takes account of the dignity of service-users
    - takes account of the participation by service-users in the community in which service-users live
    - protects and improves the safety of service-users
    - improves the quality of the service
    - is planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care)
    - best anticipates needs and prevents them arising
    - makes the best use of the available facilities, people and other resources

The purpose of the plan is to show how the whole system of health and social care in Shetland is working towards improving the health and wellbeing of the people of Shetland, as set out in the national health and wellbeing outcomes.

Integration is designed to bring about fundamental change in the way we deliver services, in order to achieve these outcomes, for instance in shifting the balance of care from institutions to the community, e.g. reducing unplanned hospital admission rates and addressing delayed discharges.

National health and wellbeing outcomes

1. People are able to look after and improve their own health and wellbeing and live in good health for longer.

2. People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

3. People who use health and social care services have positive experiences of those services, and have their dignity respected.

4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

5. Health and social care services contribute to reducing health inequalities.

6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.

7. People using health and social care services are safe from harm.

8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

9. Resources are used effectively and efficiently in the provision of health and social care

The Plan is written to identify the resources that are being used to help address these challenges, and sets out how service provision will shift over time to support anticipatory and preventative care.

Separate sections of the plan focus on particular sections of the population such as older people and adults with a disability, including physical disability and learning disability, and on specific delegated services such as primary care, mental health services and criminal justice.

The Plan also sets out the arrangements for carrying out the integration functions in Shetland over the period of the plan:

- The arrangements for each locality established for locality planning purposes – Section 2: Shetland Localities and the Locality Planning process;
- The operation of the Strategic Planning Group for the purposes of preparing the strategic commissioning plan (detail included in the briefing on Strategic Planning for Health & Social Care Integration – http://www.shetland.gov.uk/Health_Social_Care_Integration/documents/BriefingonStrategicandLocalityPlanningupdatedNov2015.pdf).
- The current CHCP Procurement Strategy will be replaced by an updated Joint Commissioning and Procurement Strategy with the ambition of providing one strategy that will be adopted by the Council, NHS Shetland and Shetland's Integration Joint Board for health and social care.

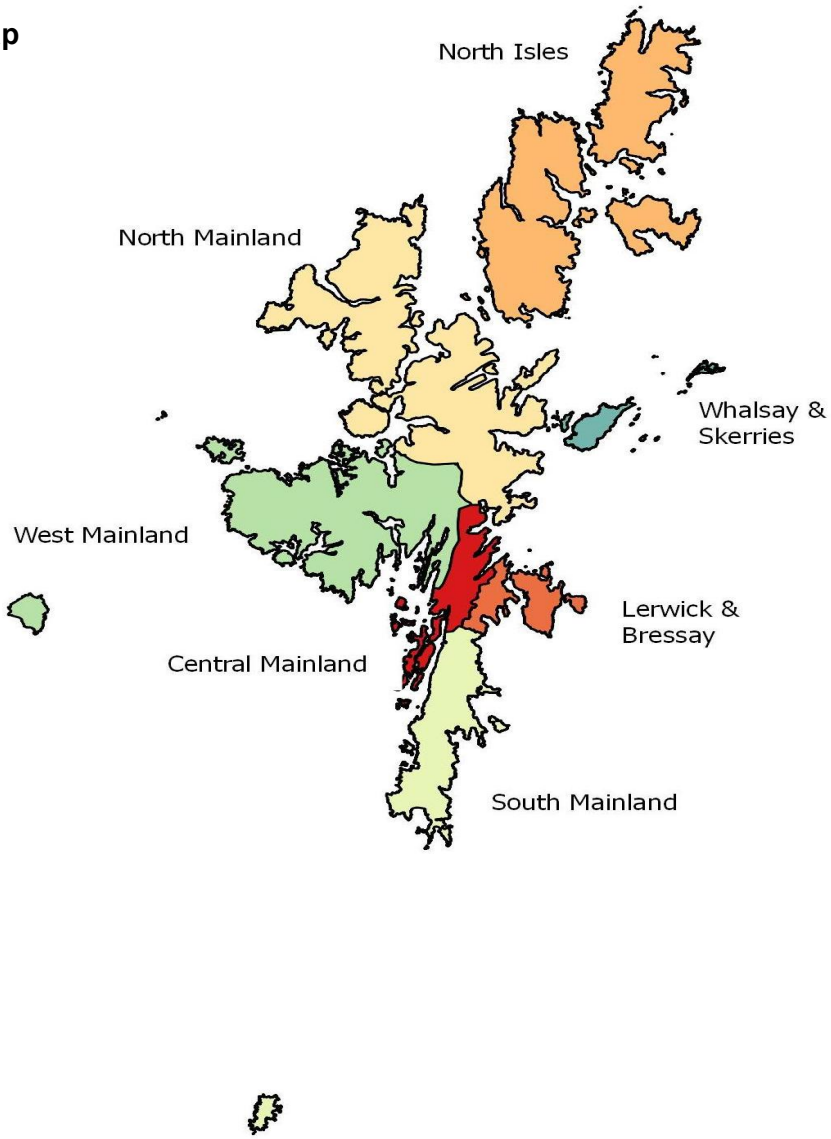
Work will be done during 2016/17 to develop an agreed and transparent option appraisal process, especially to underpin major investment and disinvestment decisions; and to develop a Market Facilitation Plan in line with national guidance as relevant to the Shetland context.

Functions that are delegated by the Health Board to the IJB and functions delegated by the Council to the IJB are listed on pages 38-57 of the Integration Scheme 2015 http://www.shetland.gov.uk/Health_Social_Care_Integration/documents/SHSCPartnershipIntegrationScheme15May2015.pdf

2. Planning In Localities

We have 7 localities based on geography and ward boundaries, used for locality planning purposes and for community planning. The views and priorities of localities must be taken into account in the development of the Strategic Plan, which means we need to develop localities in Shetland to the point where they can plan for how the Integration Authority's resources are to be spent on their local population, and the strategic plan should then consolidate plans agreed in localities.

Localities Map



Each locality has a set of services delivered within the locality:

- Primary care
- Community nursing
- Care at home and care home resources.

In addition, Occupational Therapy (OT) and health improvement have practitioners allocated to individual localities to deliver services locally and work with partner services within the locality, and social work have identified link professionals for each locality.

The details of these are currently described in the individual services sections of the plan, but the intention over time is to describe these at locality level, along with defining locality level budgets and activity. Work is currently in progress on this, and also on apportioning the activity of other services to locality level (ie showing the proportion of a service used by the people living in each locality) so that we can start to see budgets and use of services by localities to support future locality planning.

During 2015/16 a series of locality planning meetings were held across localities to engage local staff and key other stakeholders (third sector, user and carer representatives, and community leaders - Community Council and SIC councillors), and feedback of the issues identified has been passed to services to inform the development of the Joint Strategic Commissioning Plan.

This section of the Plan will be developed as this work develops.

3. Health & Social Care Integration Plans

3.1 Adult Protection Committee

Policy Context
Shetland's Adult Protection Committee was established under the Adult Support and Protection (Scotland) Act 2007, and includes membership from NHS Shetland, Police Scotland, Shetland Islands Council, Voluntary Action Shetland, Procurator Fiscals Office and the Fire Service.

Current Services
The Committee oversee the multi agency work which takes place to protect adults who may be subject to risk. They do this by producing Multi-agency Adult Support and Protection Procedures which guide what needs to be done should anyone have a concern for an adult who may be at risk; by organising, coordinating and delivering training and public awareness; by monitoring activity of the three public bodies with specific duties in the Adult Support and Protection (Scotland) Act 2007, who are Shetland Islands Council, NHS Scotland and Police Scotland.

Priorities for Adult Protection Committee in 2016-17

- Engagement with groups of service users and carers to raise awareness of adult protection
- Financial abuse - workshops for practitioners and improving joint working and information sharing with Trading Standards, Police Scotland, local banks and CAB
- Updating adult protection procedures
- Working to improve quality assurance systems- following a recommendation made by the Care Inspectorate in their Joint Inspection of Services to Older People improving scrutiny of adult protection processes and risk assessments and risk management will be priority in 2016/17
- To update and improve Adult Protection Training

Our Customers
We would want anyone who had a concern about an adult to report it. The situation may not meet the 3 point test, but the adult may still require support.

Funding and resources
The Lead Officer for Adult and Child Protection holds a budget to fund the committee's work and business plans for both APC and CPC. It is likely that in 16/17 there will be a need to make savings from the Adult and Child Protection Budget and this will pose some challenges in prioritising work.

Risks to Delivery
Protecting adults from harm is a high risk area of work for all agencies. Missing something could result in very serious consequences for an adult at risk and consequent issues for all services and staff. Reductions in the training budget and the current staffing pressures, make it difficult for staff to be released for training, are concerns for adult protection.

3.2 Adult Services

Learning Disability and Autism Spectrum Disorder Service

Policy context
There are a wide range of legislative provisions which impose powers and duties on the local authority with regard to the care and support of people with learning disabilities and autism. The main statutory duties are contained in the Social Work (Scotland) Act 1968, which establishes an overall duty to 'promote social welfare' by providing advice, guidance and assistance; the National Health Service and Community Care Act 1990 which requires the local authority to assess the individual care needs of people, including people who have care needs as a consequence of disability, mental health problems or increasing age; and in Sections 25 and 26 of the Mental Health Care and Treatment (Scotland) Act 2003. Section 25 requires the local authority to provide or arrange the provision of care and support to people who have or have had a mental disorder and are in need of services and give people the opportunity to lead lives which are as normal as possible. This can include accommodation and care at home to support both quality of life and safety. Section 26 requires the local authority to provide or arrange provision of service which promote the social development and well being of persons with a mental disorder. This includes social and recreational activities; training for people over school age; and assistance in obtaining and undertaking employment.

In addition, all social care organisations and staff are under a general duty to carry out their work in a way that promotes equality of opportunity and seeks to counter or eliminate discrimination.

Other legislation which shapes service delivery for people with learning disabilities and autistic spectrum disorders includes; Adults with Incapacity (Scotland) Act 2000; Regulation of Care (Scotland) Act 2001; Adult Support & Protection (Scotland) Act 2007; Social Care (Self-directed Support) (Scotland) Act 2013; Public Bodies (Joint Working) (Scotland) Act 2014; Carers (Scotland) Bill 2015.

Current Services
In recent years there has been a growing commitment across the health and social care to focus on the outcomes important to the person and to support families and carers maintain their caring role and have a life outside of caring. This attention to individual outcomes puts the person at the centre of support and ensures that organisations are focussed on the positive difference their involvement makes to people's lives.

Supported Living Service (SL) works in close association with SIC Housing and Hjatland Housing Association using the existing housing application process to provide supported tenancies for adults with learning disability, autistic spectrum disorder and complex needs. Outreach support for people living in their own or family home may also be available. Following assessment and allocation, each person is supported to develop a person centred plan that assists them to achieve goals and outcomes, and manages welfare and financial risks.

Supported Vocational Activity Service, the Eric Gray Resource Centre (EGRC), provides a needs led, day support service to adults with learning disabilities and autistic spectrum disorder that recognises the rights of the individual to participate as meaningfully and as independently as possible in everyday life. Assessed needs are met through a range of vocational, learning and recreational opportunities and experiences to promote inclusion, choice and independence and encourage each person to fulfil their personal goals and aspirations.

Supported Employment opportunities are provided through third sector providers including: COPE, which offers a range of supported employment placements in their small businesses and works closely with EGRC; and the Moving On Employment Project (MOEP), which provides Job Brokerage and Tapered Support to sustain people into mainstream employment.

Short Break and Respite Service, Newcraigielea. Shetland Community Health and Social Care is committed to supporting unpaid carers manage their caring role and be enabled to have a life outside of caring. Good quality and flexible support to meet the assessed needs of adults with a learning disability, autistic spectrum disorder and complex needs and those of the unpaid carer is provided through our short break and respite service at Newcraigielea. Newcraigielea also offers a day care service through the GOLD Group for older people with learning disability to meet the level of assessed need in line with eligibility criteria.

Learning Disability Nurse is a single handed, community nursing service offered throughout Shetland for people aged 5 onwards with a learning disability in addition to a health need. The nurse works with a range of services such as Education, Social Work, Supported Employment, Day and Voluntary Sector Services. There is a consultative and liaison service with Secondary Health Care, Adult Mental Health, CAMHS, Community and Children's Nursing.

Specialist Psychiatry and Clinical Psychology are provided by a visiting Consultant Psychiatrist and a visiting Clinical Psychologist offers outpatient appointments or home visits as appropriate.

Allied Health Professionals (AHPs) in Shetland work through partnerships across health, social care, education, voluntary and independent sectors with adults and children of all ages. This group of professionals includes a range of practitioners in Dietetics; Occupational Therapy; Orthotics; Physiotherapy; Podiatry; Speech and Language Therapy who work with a range of technical and support staff to deliver direct care and provide rehabilitation, self-management, "enabling" and health improvement interventions.

AHPs work concentrates on the provision of "enabling" services, shifting the focus away from professional dependency and towards supported self-management and resilience, which will be central to achieving better outcomes for people who use services, their families and carers.

Shetland Community Health and Social Care (CH&SC) is committed to providing good quality and flexible support for unpaid carers to enable them to continue in their caring role for as long as they are able to do so and be enabled to have a life outside of caring. A review of the carer strategy is underway and the final Shetland Carer Information Strategy 2016 – 20 to be published soon. This high level document strengthens the recognition of carers as equal partners in the support of the cared for person.

Shetland has recently reviewed it's With You For You (Single Shared Assessment) Procedures which has reinforced statutory service's ability to identify carers at an early stage either in their own right or through identification during a cared for persons assessment of need. Our new assessment and care management model is based on people's assets and carers' views are central to this. Carers are identified in this process and offered their own assessment and support plan.

Funding and Resources

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Adult Services	137.39	5,714,339	447,135	5,267,204	TBC

With less public funding available in 2016/17 than in 2015/16 due to a reduced settlement for local authorities, Adult Services will undertake a whole model appraisal in 2016. Delivery on findings from this work will ensure that any change delivers a sustainable and affordable service that meets the needs of clients.

Needs/Unmet needs/Drivers for change

Any individual (18+) with an assessment of need linked to their learning disability, autistic spectrum condition or complex need will be supported to develop a plan to meet those needs.

Young people age 16–18 can be at risk of falling between services for children and adults. The Children and Young People Act (Scotland) 2014 is clear that all young people up to the age of 18 should have a Named Person in place that can be a first point of contact if the young person requires advice and assistance. For some young people between the ages of 16 and 18, Shetland Inter- Agency Adult Support and Protection Procedures may apply wherever concerns are raised. Where the young person is 'Looked After' at the age of 18 the local authority has a responsibility for their care and welfare up to the age of 26.

The number of people in Shetland with learning disability, autistic spectrum disorder, profound and multiple complex needs known to the Local Authority is slightly above the national average with just over 8 people per 1000 compared to the Scottish average of 6 people per 1000 [1]. At October 2015, this translates into 197 adults with either Learning Disability or Autism Spectrum Disorder and a further 51 under 16 year olds in Shetland.

Advances in medical and social care have led to a significant increase in the survival rate and life expectancy of the population as a whole, including people with learning disabilities and autistic spectrum disorder.

As the population of people with a learning disability and autism spectrum disorder grows larger and are reaching older age, experiencing the issues associated with older age such as arthritis, the menopause and dementia, it is increasingly important to consider what enables people to remain in their own homes and have meaningful lives in their communities. With rising demand, the main challenge for the foreseeable future will be the provision of flexible, creative and responsive services to appropriately meet the statutory duties of the local authority and the personal outcomes of individuals we support within the available resources.

The Scottish Government, COSLA and ADSW have been working in partnership to review services for people with learning disability. The strategy entitled, '*The Keys to Life*' covers the period 2013 to 2023 and aims to build on themes of independence and joint working approaches from the first strategy '*The Same as You?*' (SAY), which ran from 2000 to 2010.

'*The Keys to Life*' aims to progress priority topics which include improved health outcomes, equality and the personalisation agenda. It also focuses on the potential of Self Directed Support; addresses challenges around the affordability and outcomes for people with high cost support needs and aims to advance the adult protection agenda.

Addressing need in relation to autistic spectrum disorder is recognized as a national priority. In 2011, the Scottish Government and COSLA launched the Scottish Strategy for Autism. The vision of this policy is to ensure progress across Scotland in delivering quality services to people with autism and their families, underpinned by values that have been recognised as important, namely; being respected, accepted, treated fairly, valued by the community and being able to have satisfying and meaningful lives.

Plans for change

Description	Lead Officer	Start date/ target end	Expected Outcome(s) (link to National Outcomes)
Progression of the Day Services New Build (EGRC)	Clare Scott	Started July 2014. Ongoing April 2016	• Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services. • People who use health and social care services have a positive experience of those services, and have their dignity respected.

[1] Scottish Consortium for Learning Disability Learning Disability Statistics Scotland, 2014. http://www.scld.org.uk/wp-content/uploads/2015/09/Learning-Disability-Statistics-Scotland-2014-report.pdf

Description	Lead Officer	Start date/ target end	Expected Outcome(s) (link to National Outcomes)
Holistic appraisal of Adult Services (Learning Disability and Autism Spectrum Disorder) and delivery of findings from the appraisal.	Clare Scott	April 2016	• People with LD/ASD are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community. • Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services. • People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and well-being. • Ensuring that resources are used effectively and efficiently in the provision of health and social care services and that the services provided are able to operate within the available resources.
Finalisation of Shetland Autism Spectrum Disorder Strategy, development of action plan and delivery of findings.	Clare Scott	Commenced 2015. Ongoing to 2021	• People are able to look after and improve their own wellbeing and live in good health for longer • People with ASD are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community. • People who use health and social care services have positive experiences of those services, and have their dignity respected • Public services, particularly health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

Key Risks to Delivery

Risk	Mitigation
Staff Numbers/Skill Shortage/Retention	Maximise retention of staff, develop flexibility and resilience within teams and across service area We will do this by; ensuring that staff across all service areas are engaged in the work they do and are supported to continuously improve the information, support, care and treatment they provide; ensuring that Maximising Attendance Policy is strictly adhered to; maintaining good working relations between staff and line managers; ensuring recruitment processes are LEAN and that any barriers to recruitment are dealt with promptly; continuation of Modern Apprenticeship scheme and Traineeship in collaboration with Shetland College to attract new staff; ensuring succession planning and CPD opportunities are central to review cycles.

Business Continuity Plans Inadequate	Business continuity plans are in place for each service strand in Ad.Svs - LD&ASD with contingencies plans in place to address key business failures that could impact on service delivery. Plans are monitored and reviewed a minimum of annually or as and when required.
Contractual Liabilities and Failure Of Key Supplier	Service Level Agreements (SLA) and/or Grant Condition Agreements are in place for all services purchased from local voluntary and not for profit organisations. Procedures set out in clear document available to all. Each SLA has a nominated Lead to oversee functioning of provision.
Managing Expectations of the Community	Develop user friendly, public information resources and ensure availability in a number of formats (e.g. electronic; easy read; paper; etc). Set clear criteria for services. Eligibility criteria for community care services are in place and in line with revised national guidance. This forms an integral part of the revised SSA process With You, For You.

Performance Targets with links to National Outcomes

Measure	Aim	National Outcome
Number of adults with LD/ASD obtaining a recognised qualification in lifelong learning; personal development; maintaining skills	Adults with learning disability, autistic spectrum disorder and/or complex needs are supported to have a safe, healthy and active life. Self-care and enablement approaches are promoted	Outcome 4 - Health and social care services are centred on helping to maintain or improve the quality of life of service users
Number of emergency respite nights provided for adults with LD/ASD. *An incident of Emergency Respite is one or more consecutive overnight stay/s out with the assessed needs allocation of overnight respite stays.*	Advance Care Plans will be developed with people, those close to them and service providers to make decisions with respect to their future health, personal and practical aspects of care and support. The risk of unscheduled care will be reduced.	Outcome 6 - People who provide unpaid care are supported to reduce the potential impact of their caring role on their own health and wellbeing
Number of Social Care staff trained to implement Positive Behaviour Support.	Staff will have the knowledge and theory of Positive Behaviour Support and be able to put into practice in the support they provide.	Outcome 8 - People who work in health and social care services are supported to continuously improve the information, support, care and treatment they provide and feel engaged with the work they do

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Further Reading

Keys to Life. Improving quality of life for people with learning disabilities.
http://www.gov.scot/resource/0042/00424389.pdf

Scottish Government's Scottish Strategy for Autism Website. This website will keep you informed about current developments, news and events and progress relating to the strategy.
http://www.autismstrategyscotland.org.uk/strategy/linking-goals-aims-and-recommendations.html

Mental Health Care and Treatment (Scotland) Act 2003
http://www.scotland.gov.uk/Publications/2005/08/29100428/04330

Comprehensive information on the provisions of the relevant legislation is available from the Scottish Government website http://www.gov.scot/Home

Safeguarding Children, Young People and Adults in Shetland
http://www.safershetland.com/

3.3 Adult Social Work

Policy context

- Integration of health and social care and implementation of Health and Wellbeing Outcomes
- Self directed support
- Carer's legislation
- Inspection regime

Current Services

The Service comprises a team of professionally qualified social workers, support workers and administration support staff who undertake a range of statutory social work functions, primarily in three areas:

Community Care Assessments, including carers assessments and support plans and Care Management - screening referrals to establish whether or not a social work response is required. This area of work may result in -no further action - offer of advice - signposting or referral to other service areas - referral to social work assessment, including carers assessment. Assessment of social need and care management – assess whether or not an adult (aged 18 or over) requires support. For complex cases the team will manage the case, this is called care management.

Adult Support and Protection – receive and assess adult protection referrals which involves working with police and health services, investigate whether or not an adult is in need of protection from abuse. If this is the case a protection plan will be put in place to support the individual. This will be care managed by a social worker. Additionally working with adults who are subject to protection plans to reduce risk of abuse and to provide them with support.

Mental Health Officer functions - Mental Health assessment, support and intervention – assess whether or not an individual requires support due to a mental health disorder. There are a number of specific functions only a Mental Health Officer can perform.

Funding and Resources

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Adult Social Work	19.29	1,753,689	89,103	1,664,586	TBC

Needs/Unmet needs/Drivers for change

The Adult Social Work Team provides a service to any adult who requests or requires an assessment under the legislation listed above. Customers include adults with dementia, mental health difficulties, brain injuries, lifelong conditions, learning disabilities, physical disabilities, older and frail people, carers and those at risk of abuse.

The amount of people supported by this service through care management is typically around 220 at any one time. The number of people supported on a short term basis, either through screening or assessment will be higher than this and can fluctuate.

Population projections for our customer base show the following:

Adults

The population of adults (18-64) is predicted to decrease by 6.6% (13,691 to 12,791) between 2013 and 2023 and by 15% by 2033 (to 11,641).

Over 65's

The population of over 65's is predicted to increase by 32% (4,200 to 5,544) between 2013 and 2023 and by 65% by 2033 (to 6,924).

Over 85's
The population of over 85's is predicted to increase by 44% (533 to 769) between 2013 and 2023 and by 143% by 2033 (to 1,294).

The drivers for change for Adult Social Work are:

1) To ensure appropriate involvement in the integration agenda through locality working.
2) Through Self-directed Support continue to enable people to achieve better outcomes through enhanced choice.
3) Implement the recommendations from the recent inspection of services to older people, including improvements to risk assessment and risk management.

Plans for change

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
Quality assurance framework to be further developed for the service to ensure that rapid changes across the sector can be responded to in a way that minimises risks	Executive Manager Adult Social Work	Target September 2016	People using health and social care services are safe from harm
Extend the input and presence of social work in localities	Executive Manager Adult Social Work	Target September 2016	People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

Key Risks to Delivery

Risk	Mitigation
Reductions in services elsewhere due to less funding being available	Timely assessments, that are goal orientated, are client led, and where more signposting to alternatives takes place.

Performance Targets with links to National Outcomes

Performance Measure	Performance Statement	National Outcome
Number and percentage of assessments completed on time	Ensure all assessments are completed on time	Outcome 1 – People are able to look after and improve their own health and wellbeing and live in good health for longer Outcome 2 – People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home and in a homely setting in their community Outcome 3 - People who use health and social care services have positive experiences of those services, and have their dignity respected

Performance Measure	Performance Statement	National Outcome
		Outcome 6 – People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing
Number and percentage of reviews completed on time	Ensure all reviews are completed on time	Outcome 1 – People are able to look after and improve their own health and wellbeing and live in good health for longer Outcome 2 – People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home and in a homely setting in their community Outcome 3 - People who use health and social care services have positive experiences of those services, and have their dignity respected Outcome 6 – People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing
Number and percentage of outcomes for individuals are met	Outcomes are improved for individuals	Outcome 1 - People are able to look after and improve their own health and wellbeing and live in good health for longer Outcome 2 – People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home and in a homely setting in their community Outcome 3 – People who use health and social care services have positive experiences of those services, and have their dignity respected Outcome 6 – People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing

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3.4 Community Care Resources

Policy context
In March 2010, Reshaping Care for Older People: A Programme for Change 2011-2021 set out the Scottish Government's vision and immediate actions for reshaping the care and support of older people in Scotland.

The programme provides a framework, built on consensus across all sectors and interests, to address the challenges of supporting and caring for Scotland's growing older population into the next decade and beyond. It aims to improve the quality and outcomes of current models of care, whilst developing services in a sustainable way that address current demographic and funding pressures.

New legislation, in the form of the Public Bodies (Joint Working) (Scotland) Act 2014 came into force on 1 April 2014. The Act requires Health Boards and Local Authorities to integrate their health and social care services. Integration is focused on person-centred care, health, planning and delivery so people get the right advice and support in the right place and at the right time.

The new Carers (Scotland) Act 2016 will be commenced in 2017-18.

The package of provisions in the Act is designed to support carers' health and wellbeing. These include, amongst other things:

- a duty on local authorities to provide support to carers, based on the carer's identified needs which meet the local eligibility criteria. National matters which local authorities must have regard to when setting their local eligibility criteria will be set out in regulations;

- a specific Adult Carer Support Plan and Young Carer Statement to identify carers' needs and personal outcomes; and

- a requirement for each local authority to have its own information and advice service for carers which must provide information and advice on, amongst other things, emergency and future care planning, advocacy, income maximisation and carers' rights.

The Act contributes to the Scottish Government's vision of a healthier and fairer Scotland, and sits within the wider policy landscape including: integration of Health and Social Care; GP contract; National Clinical Strategy; new social security powers; and Fair Work agenda.

Current Services
The Community Care Resources provides services to adults in need across Shetland. Our purpose is to enable people to remain within their own homes and communities by providing person centred care to increase levels of independence, self-care and self-managed care. We reduce unplanned, emergency and inappropriate admissions to hospital and facilitate early discharge from hospital wherever possible through the use of Care at Home and Care Centre resources. The service has the following elements, delivered from a number of localities around Shetland:

- Residential care used for long term care or short breaks (respite)
- Day services
- Care at home
- Domestic
- Meals on Wheels

Unpaid Carers
The care provided by family and friends is intrinsic in enabling some individuals to live an independent lifestyle. The role of informal carers is becoming more recognised both nationally with the introduction of the Carers (Scotland) Act 2016 and locally with the Carers Service Plan. We

are committed to supporting unpaid carers in their caring role through increasing the range, flexibility and quantity of support for carers in partnership with the third sector.

Funding and Resources

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Community Care Resources	396.31	16,173,533	5,661,744	10,511,789	TBC

Needs/Unmet needs/Drivers for change

- Our population is ageing fast. In Shetland it is anticipated that by 2016, the number of people aged 65 or over will be 38% greater than in 2006 and 92% greater by 2031. This is higher than the national average and the fourth highest rate of change across Scotland's 32 local authorities. The biggest challenge for the foreseeable future will be to maintain, with limited resources, both the level and quality of care the people of Shetland have come to expect;
- Growing public expectations that services will be high quality, tailored to their needs and help them to achieve their personal goals and aspirations;
- Difficulties in recruiting and retaining social care staff;
- Demographic change with increasing life expectancy, a larger older population, greater social mobility of the population and a rise in the number of people living alone;
- Increasing prevalence of long term conditions and increasing multiple morbidity;
- Reductions in public and Shetland Charitable Trust funding and difficulties in recruiting will challenge the way care is delivered in Shetland. The sustainability of services needs to be addressed in order to ensure that the model of care delivered is fit for purpose.

Plans for change

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
Review current models of care in Shetland to ensure sustainability of service.	Director of CH&SC	Sept 16	Outcome 9 -Resources are used effectively. Outcome 2 -People with disabilities, long term conditions or who become frail are able to live as safely and independently as possible in the community, and have control over their care and support.
To work with locality partnerships to plan / deliver local services.	Team Leaders	Sept 16	Outcome 3 -People have positive experiences of health, social care and support services, which help to maintain or improve their quality of life.
Review roles and responsibilities within the care sector.	Executive Manager	Nov 16	Outcome 8-People who work in health and social care services are positive about their role and supported to improve the care and treatment they provide.

Sector review of procedures and processes	Executive Manager TLs	Dec 16	Outcome 9 – Effective use of resources, avoiding waste and unnecessary variation.
To work with unpaid carers, the third sector and statutory partners to draw up an action plan for the implementation of carers legislation /strategy	Executive Manager / VAS	August 16	Outcome 6 - People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.

Key Risks to Delivery

- During 2014-2015 the Community Care Resource service has experienced significant difficulty with recruitment, particularly with regards to community based social care workers. A recruitment campaign was commenced and contracted hours and rota patterns were remodelled. This remains a high risk area.

- Reductions in public funding and Shetland Charitable Trust funding will impact on the way we deliver services if the status quo continues. The way care is delivered in Shetland and the sustainability of services needs to be addressed in order to ensure that the model of care delivered is fit for purpose.

Performance Targets with links to National Outcomes

Measure	Outcome
Percentage of people over 65 being supported in a non institutionalised setting	Outcome 2 - People, including those with disabilities, long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
Percentage of people receiving intensive care at home	As above
Number of over 65's receiving Personal Care at Home.	As above
Delayed discharge from Hospital - no delays exceeding 14 days	Outcome 7 - People who use health and social care services are safe from harm
Delayed discharge from care centres - no delays exceeding four weeks	As above
Number of individuals identified as having unmet need	As above
Risk and need assessment and support plans in place within 7 weeks.	As above
Occupancy of care homes	Outcome 9 - Resources are used effectively in the provision of health and social care services, without waste
Number of Carers identified	Outcome 6 - People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.
Number of Carers Assessment Offered and Undertaken.	As above

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Further Reading

- Social Work Services, Care Homes, Respite Providers and Care At Home Services are subject to inspection by the Care Inspectorate www.careinspectorate.com

- The manager of each service area must be registered with the Care Inspectorate as a Registered Manager. Each service is inspected at least annually by the Care Inspectorate and is measured against the National Care Standards. All social care staff must be registered with Scottish Social Services Council in order to practice and must abide by the Codes of Practice. www.sssc.uk.com

3.5 Community Nursing

Policy context
The Scottish Government's 2020 vision is "that by 2020 everyone is able to live longer healthier lives at home or in a homely setting". NHS Scotland notes that they will achieve this vision by delivering a healthcare system which has

- An Integrated Health & social care service;
- A focus on prevention, anticipation, and supported self management;
- Person-centred care, delivered to the highest standard of quality and safety;
- Care provided in community settings unless hospital treatment is required; and
- People back to their home/community as soon as possible with minimal risk of readmission.

The national population demographic of an ageing population with individuals living longer, with more complex healthcare needs, and with more long term conditions is also reflected locally. Within this context, the Community Nursing service has an integral role to play in achieving the delivery of the Scottish Government's 2020 vision.

A national review of District Nursing services is scheduled to report in June 2016 and this, as well as the new GP contract being developed for implementation in April 2017, will influence the shape and delivery of nursing services in the community setting for the future.

Current Services
The Community Nursing Service comprises a range of services which provides nursing care, treatment and support within a community setting.

The District Nursing service is the largest part of Community Nursing services, which provides a nursing service to individuals within their own home, or a care home, on a 24 hours a day, seven days a week, 365 days a year basis.

The District Nursing service provides

- Acute care at home;
- Complex care at home;
- End of life care at home.

The following groups of staff who provide care in a community setting are also provided, and managed, via the Community Nursing service:

- Practice Nurses – the Practice Nursing service for all of the NHS Board provided general practices, namely Lerwick, Yell and Whalsay;
- Advanced Nurse Practitioners – the Advanced Nurse Practitioner posts based at the Lerwick Health Centre;
- Specialist Nurses, eg Continence Nurse Advisor;
- Non-Doctor Island/Out of Hours Nursing – there are resident nurses on the non-doctor islands of Fair Isle, Foula, Fetlar, Skerries and Bressay. Some of these postholders, along with their relief colleagues, provide the overnight nursing service on mainland Shetland; and
- Intermediate Care Team – this multi-disciplinary, partnership team provide additional support at home for individuals to prevent unnecessary admission to hospital or provide additional support to increase independence on discharge home from hospital. This additional support is provided on a time limited basis of up to 6 weeks. The team are based at the Independent Living Centre, Gremista, Lerwick.

Whilst the Community Nursing Services predominantly provide a front line clinical service to individuals who are over the age of 16years and are housebound, the services will endeavour to meet the needs of any individual across the lifespan from birth to death, within the community setting who have a nursing and/or health need. Community Nursing staff also provide support and

teaching to informal or family carers to enable them to care effectively for their relative, whilst also addressing any care and support needs the individual carer might have themselves.

All of the component services within Community Nursing services work together with the aim of maintaining as many individuals as possible at home within a community setting wherever possible.

Funding and Resources
The overall Community Nursing Services has approx 47.65 full time equivalent staff and an annual revenue expenditure of £2.3 million. The staffing establishment is as detailed below:

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Community Nursing services	47.65	2,333,629	4,075	2,329,554	240,000

Needs/Unmet needs/Drivers for change
The service priorities have been informed by both national and local drivers for change and are aimed at enhancing service delivery at locality level. The actions outlined should respond to the issues of importance to local communities, which have been identified through the round of Locality Planning meetings. Consideration has also been given to additional service specific information which has been gained by engagement with various groups eg patient satisfaction survey for ANP service at Lerwick Health Centre, General Satisfaction survey across all of District Nursing and Continence Service, discussions with Community Councils regarding sustainability of provision of health services.

Service Aims/Priorities	Objectives/Actions
There will be a demonstrably healthier local population who are able to remain in their own homes or in a homely environment for as long as they so wish.	All community based nurses will promote healthy lifestyles to all individuals on the caseload. Anticipatory care plans will be developed with individuals in order to support them manage their own condition as well as to remain in their own homes for as long as possible.
The balance of activity will have moved towards locally provided service delivery, where it is appropriate and value for money to do so	District Nurses/Community Nursing service will work as part of a locality service delivery model, influencing and leading care for individuals with a health need.
Where possible a customer will have allocated to them a named individual who looks after their service needs so that they need only have to “tell their story once”.	District Nurses will actively adopt the case manager role for individuals with complex health needs, where appropriate.

Plans for change

New Planned Actions Due to Start in 2016/17					
Title/Heading	**Team**	**Start**	**End**	**Output**	**Expected Outcome/Supported Aims/Objectives**
Further develop sustainable Intermediate Care Team with integral overnight nursing/care service	Intermediate Care Team	April 2016	July 2016	Sustainable service in place	Provides a 24hour nursing and care service at home thus supporting early supported discharge from hospital as well as avoiding unnecessary admissions
Source Emis Community as a potential electronic solution to record keeping for Community Nursing with interface to GP record, social care and secondary care	Chief Nurse	April 2016	March 2017	Electronic record keeping/management system in place	Enhance communication across multidisciplinary, interagency teams thus supporting improved seamless care for individuals
Further develop model of case management within Community Nursing services	Chief Nurse / Clinical Team Leaders	Ongoing		District Nurses undertake case management role	Better co-ordinated care for individuals with complex health needs
Continue to support implementation of eKIS Anticipatory Care Planning across the services	Chief Nurse /Clinical Team Leaders	Ongoing		Increase in eKIS plans in place across all General Practices in Shetland	Enhance anticipatory approach to care for individuals with complex health needs.
Conduct review of local District Nursing services in line with national "Transforming Nursing Roles" project	Chief Nurse	April 2016	September 2016	Ensure that District Nursing workforce locally continues to develop in line with national direction	District Nursing workforce is fit for purpose for 21st century Role of District Nurse in Locality based teams is confirmed
Review of skill set across Nursing and Care staff	Chief Nurse / Exec Manager Community	Ongoing	September 2016	Agreed roles / skill sets across nursing and care staff	Better utilisation of staff within integrated team

New Planned Actions Due to Start in 2016/17					
Title/Heading	**Team**	**Start**	**End**	**Output**	**Expected Outcome/Supported Aims/Objectives**
	Care Resources				
Develop Nursing in Community Strategy	Chief Nurse	September 2016	March 2017	Set strategic direction for nursing in community settings	Strategy developed to support careers in nursing in a community setting which provides a career framework from initial registration to Advanced Practice. Nursing service supports implementation of new GP contract from April 2017
Review model of service provision in remote areas	Chief Nurse With key partners	April 2016	March 2017	Service model which meets health needs of island communities	Sustainable, safe, effective, person-centred service in place

Key Risks to Delivery
During 2015-2016 the Community Nursing service has continued to experience significant difficulty with recruitment in the service, the effects of this in terms of service provision, being further compounded by a number of staff who have had a period of long term sickness absence whilst awaiting or recovering from surgical interventions.

A number of these issues have now been resolved but these issues have had an impact on service development in 2015/16 as staff have had to focus on meeting the current clinical needs of patients on the active caseloads.

Any further recruitment/retention issues leading to ongoing reduced staffing levels will have a significant impact both on service delivery and on the ability of the service to take forward the initiatives above within the timescales outlined.

The Community Nursing service has previously made approximately £500,000 of savings and is currently facing a further savings challenge to £240,000. Some of the projects outlined above have the potential to identify savings but have various risks associated both with delivering these and with delivering them within the outlined timescales.

Performance Targets with links to National Outcomes
The overall aims and objectives of all the constituent parts of the Community Nursing services are to:

- Support and maximise the health potential of individuals, as well as address the health and care needs of various client groups and/or their carers within the wider community; and
- Utilise a holistic approach to providing safe, effective, person-centred care in a variety of community settings.

These aims and objectives contribute to the delivery of the National Health and Wellbeing Outcomes, in particular:

Outcome 2: People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community

Outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

Outcome 6: People who provide unpaid care are supported to reduce the potential impact of their caring role on their own health and wellbeing

Performance Measure	Performance 2015/16	Target 2016/17
Number of Early Supported Discharges		
Number of Admissions Avoided through involvement of Intermediate Care Team		
Number of individuals with complex health needs whose care is case managed by a District Nurse		
Number of Anticipatory Care Plans in place and shared across services		
Number of early supported discharges with no re-admission in 30 days		
Number of people supported to die in preferred place of care		
Number of people supported to have a solution to their continence problem which is not a containment solution		
Number of individuals seen by an Advanced Nurse Practitioner as first point of access to healthcare		
Number of individuals seen by an Advanced Nurse Practitioner who subsequently referred to another practitioner for a “second opinion”		
Patient Satisfaction survey of patients seen by Advanced Nurse Practitioners		

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3.6 Criminal Justice

Policy context
The Strategy for Justice in Scotland sets out the Government's approach to make the Scottish justice system fit for the 21st century. The second phase of the Reducing Reoffending Programme which began in 2012 is focused on making sure that the right services and support are provided so that prolific offenders can address their reoffending and its causes.

Criminal justice social work services are statutory partners in ensuring effective community justice in local communities. Community Justice is currently the responsibility of Community Justice Authorities; however, following a redesign as set out in the draft Community Justice (Scotland) Bill, CJA's will be disbanded on 31 March 2017. From the 1 April 2017 responsibility for community justice will be transferred to 'community justice partners', with oversight and assurance to Ministers being given by a new national body, Community Justice Scotland. In Shetland, a local Community Justice Partnership will be established and will report to the Shetland Partnership. The Partnership will be responsible for producing a strategic plan that will address local and national priorities. A transition plan is being formed and will be submitted to the Scottish Government in 2016.

Current Services
The Service comprises of a small team of professionally qualified social workers and support workers who undertake a range of statutory social work functions that ensures all people who commit offences are appropriately assessed, supervised and risk managed. The service is responsible for the delivery and development of all criminal justice social work services throughout Shetland. This includes the production of court reports and risk assessments to aid the Court in making effective sentencing decisions; reducing reoffending and public protection through supervision and management of offenders who are subject to community based sentences and rehabilitation of offenders who have been subject to custodial sentences.

Funding and Resources
Funding for Criminal Justice Social Work Services is ring fenced and allocated by the Northern Community Justice Authority on an annual basis. The funding covers the meeting of statutory duties. The service works collaboratively with other statutory and third sector partners in Shetland to ensure that receive the assistant and support their need to stop their offending behaviour.

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Criminal Justice	7.37	358,483	329,334	29,149	TBC

Needs/Unmet needs/Drivers for change
The main driver for change is the redesign of community justice which evolved from the Commission on Women Offenders Report and Audit Scotland's evaluation of Community Justice Authorities. The service also takes account of relevant evidence as summarised in the 2011 report "What Works to Reduce Reoffending: A Summary of the Evidence".

Women who offend
http://www.scotland.gov.uk/News/Releases/2012/04/womenoffenders17042012

Plans for change

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
Participate in the transition phase of the Redesign of	Executive Manager	April 16	Reduce reoffending / Safer Communities.

Community Justice at a local and national level.			
To work with local partners and partnerships to plan / deliver local services.	Executive Manager/ Senior Social Worker	Sept 16	Offenders within Shetland have the best opportunities to make positive changes to their lives.
To contribute to the National outcomes, performance and improvement framework.	Executive Manager	Oct 16	An outcome focussed approach to the planning and delivery of community justice services.
Review of processes and procedures to ensure they remain fit for purpose	Executive Manager	Jan 17	The most effective use is made of resources across health and social care services, avoiding waste and unnecessary variation.
Continue to promote increased use of fiscal and police direct measures.	Senior Social Worker	April 16	Fewer people appearing in Court.

Key Risks to Delivery
The future funding formulae for criminal justice social work has not been decided. Any reduction in annual funding will have a significant impact on the delivery of service and the service's ability to meet statutory duties and contribute to community safety.

Performance Targets with links to National Outcomes

Measure	Outcome
Percentage of people commencing supervision within 7 working days of being sentenced.	People have access to swift justice.
Percentage of court reports submitted on time.	People have access to swift justice.
Percentage of risk and need assessment completed within 20 days.	Reduce reoffending.
Percentage of individuals showing a decrease in assessed risk and need at end of order	Reduce reoffending.
Percentage of Unpaid work commenced within 7 working days.	Reduce reoffending.

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3.7 Domestic Abuse (Gender Based Violence)

Domestic Abuse and other Gender based violence services in Shetland are delivered by a number of organisations and departments within the Voluntary Sector, Shetland Islands Council, Police Scotland and NHS Shetland, which come together at a strategic level through the Shetland Domestic Abuse Partnership.

Policy context
Equally Safe, the Scottish Government and COSLA's joint strategy for preventing and eradicating violence against women and girls (VaWG) was launched in 2014. Equally Safe is Scotland's strategy to tackle all forms of violence against women and girls: domestic abuse, rape and sexual assault; sexual harassment and intimidation at work and in public; stalking; commercial sexual exploitation such as prostitution, pornography and human trafficking; dowry-related violence; female genital mutilation (FGM); forced marriage; and so-called 'honour' based violence. The strategy recognises that women and girls are at risk of such abuse precisely because they are female and it aligns with the UN definition of violence against women. Clearly, boys and men can also experience violence and the strategy does not diminish the seriousness of that experience or proposing to alter the support on offer to them. However the strategy aims to highlight that being female in itself can lead to a range of discrimination and disadvantage, including experiencing male violence. Furthermore violence against women can have significant consequences beyond those experienced by the individual. Children and young people growing up in the same family setting can be badly affected, whether as victims of violence directly or as witnesses to violence. VaWG is underpinned by gender inequality, and in order to prevent and eradicate it from society efforts must be focused on delivering greater gender equality, tackling perpetrators, and intervening early and effectively to prevent violence.

The Shetland Domestic Abuse Strategy 2013-16 www.shetland.gov.uk/news-advice/documents/SDAPStrategy2013-16.pdf and associated action plan sets out how the Partnership currently addresses and prevents domestic abuse and gender-based violence in Shetland. The strategy is being revised in response to Equally Safe and building on a needs assessment to develop a new strategy for 2016-19.

Current Services
The needs of people affected by domestic abuse cannot be met by a single service alone. The following services in Shetland are involved in delivering the action plan, and most are represented on the Partnership:

- Shetland Women's Aid
- Shetland Islands Council (including Adult & Child Protection; Criminal Justice Social Work, Housing Service, Schools Service, Adult Services Social Work, Children & Families Social Work , Community Development)
- Police Scotland
- NHS Shetland (including Reproductive Health Services, A&E, Primary Care; Community Nursing and Health Visiting, Public Health, Substance Misuse Recovery Service and Mental Health Services)
- Victim Support Shetland
- Rape Crisis Shetland
- Hjaltland Housing Association
- Local solicitors

The only service from this list above that is dedicated to domestic abuse in Shetland Women's Aid which is a registered charity offering counselling, advice and support to women, children and young people. It also provides refuge accommodation for women, and their children, who are being or have been physically, emotionally or sexually abused. The accommodation can house one family at a time.

For all the other services, responding to domestic abuse and other forms of gender based violence is one element of their overall service.

MARAC
In 2013, the MARAC (Multi-Agency Risk Assessment Conference) was launched in Shetland. This is a monthly, local meeting where information about high risk domestic abuse victims (those at risk of murder or serious harm) is shared between local agencies. By bringing all agencies together at a MARAC, and ensuring that whenever possible the voice of the victim is represented by the Independent Domestic Abuse Advocate (IDAA), a risk- focused, co-ordinated safety plan can be drawn up to support the victim. In Shetland the MARAC is now coordinated through Safer Highland and overseen by the Safer Highland Steering Group which reports to the Domestic Abuse Partnership and in turn the Senior Officer Group. There is dedicated funding and staffing for this service(see below).

Information on the roles of other services can be found in their individual service plans and here (SDAP Directory of Support Services)
www.safershetland.com/assets/files/Signposting%20Leaflet%20(V2%20June%202013).pdf

It is not currently possible to identify the total Domestic Abuse Services budget, however the budgets and workforce for the two services that are dedicated to Domestic Abuse (Shetland Women's Aid and MARAC) are outlined below. The funding and resources in other services and organisations that are used to provide domestic abuse services can not currently be separated out from their overall budget allocations and work force.

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Shetland Women's Aid (funded by SIC Housing Dept; Big Lottery; Scottish Government VAW fund)	N/A	N/A	N/A	N/A	N/A
MARAC (funded by VAW fund until June 2016; funds for a further year applied for)	N/A	N/A	N/A	N/A	N/A

Needs/Unmet needs/Drivers for change
- Recognition of the actual incidence or potential for other gender based violence issues in addition to domestic abuse including human trafficking; forced marriage; sexual assault and rape; childhood sexual abuse; harmful traditional practices; stalking and sexual exploitation.
- Lack of sufficient refuge accommodation.
- Clients are presenting to services with increasingly complex needs.
- As awareness raising, publicity and routine enquiry is further developed and implemented, then more people who have experienced domestic abuse are likely to present or be identified.

Plans for change

Description	Lead Officer	Start date/target end date	Expected Outcome(s) (link to National Outcomes)
Strategy for 2016-19 currently in development	Susan Laidlaw	In progress - to complete by July 2016	**Outcome 4.** Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services **Outcome 5.** Health and social care services contribute to reducing health inequalities **Outcome 7.** People using health and social

			care services are safe from harm **Outcome 9:** Resources are used effectively and efficiently in the provision of health and social care services
Action plan for 2016-17 to be developed in response to Strategy	Susan Laidlaw	In progress - to complete by July 2016	**Outcomes 4,5,7,9**

Key Risks to Delivery

- During 2014, the SDAP chair and the Community Safety Officer, who was the lead officer for the Partnership both left their posts. The chairmanship is currently being picked up on an interim basis. Some of the administrative functions of the lead officer role have been picked up through Community Planning, but we do not have the dedicated input that was previously provided by the Community Safety Officer.
- Womens Aid, like most voluntary sector organisations, is dependent on short term funding awards.
- The current one year funding for the MARAC runs up to the end of June 2016; further funding is therefore being applied for.
- Because the other agencies that are involved in tackling domestic abuse and gender based violence have this as only a relatively small part of their remit, there is a risk that services will be diminished as resources become more scarce for every service.

Performance Targets with links to National Outcomes

Performance targets to be developed through the Strategy Development, informed by national work in this area; will specifically link with Outcomes 4, 5 and 7 above.

Local Outcome Improvement Plan: There are a number of actions for the Domestic Abuse Partnership within the priority 'Keeping People Safe' to achieve the Outcome: Shetland is a safe place for all our people, and we have strong resilient and supportive communities. ' .

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3.8 Intermediate Care

Policy context
The background to the implementation of intermediate care is detailed in the Scottish Government's Reshaping Care for Older People strategy: http://www.scotland.gov.uk/Resource/0039/00398295.pdf and in the Intermediate Care Framework for Scotland: http://www.scotland.gov.uk/Resource/0039/00396826.pdf

The Reshaping Older Peoples Care Agenda aims to reduce unplanned admissions to hospital or long term care, enhance discharge planning, recovery and self-management.

Some of the key drivers behind this agenda are:

- HEAT Targets – the delayed discharge target is for no person to wait more than 14 days to be discharged from hospital into a more appropriate care setting from April 2015.

- AHP National Delivery Plan (Scottish Government, 2012) http://www.scotland.gov.uk/Resource/0039/00395491.pdf
  - Action 2.3 AHP directors will work with directors of social work and their NHS boards to maximise the AHP contribution to achieving delayed discharge targets and reduce overall length of stay in hospital, which will support the delivery of the legal treatment time guarantee.

  - Action 2.4 AHP directors will work with directors of social work to support older people and those with disability and complex needs to live independently in their own home/homely setting for as long as possible, delaying or reducing admissions into institutional care.

  - Action 2.5 AHP directors will work across directorates of social work and NHS to reconfigure "enabling" services, such as rehabilitation and reablement, to deliver best value and enhance care experiences for people who use services and their families and carers. This will transverse and enhance the experiences of the clients by addressing the holistic needs of the individual clients, family and relative carers. The services to be delivered on a one to one bases following a multi professional assessment.

Current Services
Intermediate care will deliver the following:

- Individuals will be supported to remain at home, thus avoiding unnecessary admissions to the hospital;
- Individuals will be supported home from hospital and can receive 24 hour care at home for the first 5-7 days thus providing time to undertake further assessment of need once at home and within familiar surroundings;
- Enhanced care to palliative care patients who can receive additional nursing care and support on a 24/7 basis;
- Provision of support and advice to care centre staff on the management of clients with nursing, healthcare and therapy needs;
- Enhanced therapy input to ensure functional abilities are maximised.
- Additional "enabling" and "reabling" input through therapy assistant input.
- Assessment of individual patient needs on a 24/7 basis by Registered Nursing staff.
- First point of access to healthcare for patients with care needs via support/advice/assessment provided by District Nurses/Nurse Practitioners contacted directly by care staff.

The Intermediate care team has to deliver the following outcomes:

- Reduction in numbers of individuals admitted to the Gilbert Bain Hospital or residential setting with primarily a social or nursing care need;
- Reduction in emergency admissions to the GBH and residential care.
- Increase in the number of people successfully returned to a home / residential care setting post GBH admission;
- Increase in number of people who could be considered to be cared for primarily in a community setting due to support being available from the overnight nursing and care team.

Funding and Resources – *funded by Integrated Care Fund 2016/17*

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Intermediate Care Service	13.18			443,247 (410,000 from 2016/17 funding with 33,247 carried forward from 2015/16)	0

Needs/Unmet needs/Drivers for change
Service redesign is based on the availability of funding for the next financial year. The service is currently expanding to meet the needs of a growing elderly population.

Plans for change
Currently the service has been developing for the past 12 months. Service evaluation is currently being taken place.

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
Extend intermediate care model to all localities using investment opportunities and through redesign of teams.	Chief Nurse Community Executive Manager AHPs	Target Oct 16	People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

Key Risks to Delivery
Funding cuts are a viable risk. Audit is being conducted on a regular basis to show the cost saving of patients in the community setting versus hospital settings. This will show over the next finical year a trajectory of service delivery thus meeting the needs of the national outcomes measures.

Performance Targets with links to National Outcomes
Outcome 2 - People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
Outcome 4 - Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

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3.9 Mental Health

Policy context
The Mental Health (Care and Treatment) (Scotland) Act 2003 came into effect in October 2005. The Act contained much more than simply legislation for new forms of compulsory powers and safeguards. Its underpinning principles heralded a new era of rights-based care for people who use mental health services. As well as providing care and treatment, services are now required to promote social inclusion and a wider citizenship agenda.

A number of policy documents have shaped the development of local mental health services: Delivering for Mental Health (2006) set out national policy for the development of Mental Health services and the improvement of mental health in Scotland. This was followed by Better Health Better Care (2007) which established additional improvement objectives and National Targets/Standards. In 2009, Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011 outlined the roles and responsibilities of government, local public agencies and third partner agencies in promoting positive mental health.

In August 2012, the Scottish Government published a Mental Health Strategy for Scotland with a renewed emphasis on "prevention, anticipation and supported self management". This focus is central to mental health policy in Scotland and the strategy emphasises a range of improvements and interventions that are in accordance with the best evidence for return against investment over time. The strategy focuses on actions that people can take for themselves and with their communities to maintain and improve their own mental health.

Other strategies closely associated with the 2012 strategy for the delivery of mental health services are Suicide Prevention, Dementia and Substance Misuse.

An updated Mental Health Strategy for Shetland, written in accordance with Scottish Government priorities was agreed by Shetland Islands Council and NHS Shetland in May 2014. The over arching aim of the Shetland Mental Health strategy is to have a single plan that will deliver comprehensive mental health services; use available resources to deliver services in the most effective way and avoid harmful gaps and wasteful overlaps. This will involve health, social care, housing, education, and employment, voluntary and other agencies working jointly in the provision of complementary services across the whole spectrum of mental health support and treatment.

The vision of a 21st century mental health service for the people of Shetland is build upon the principle of person centred partnership with patients, carers and staff. This principle will be at the heart of our service change and improvement initiatives.

Current Services
The Adult Mental Health Service[2] comprises a number of statutory and front-line services and it has specific responsibilities in respect of *The Mental Health (Care and Treatment) (Scotland) Act 2003* and associated legislation and policy. The services can be accessed via a GP by means of an Electronic Single Point of Referral. The aim of the service is to deliver safe and effective care, with people being seen by the right practitioner at the right time.

The Mental Health Service is led by the Service Manager with the support of a 7 person operational team composed of a Clinical Director, 5 Service Leads and a Social Care Manager. The seven operational services that make up Shetland's Adult Mental Health Service are:

- Community Psychiatry Services (CPS)
- Community Psychiatric Nursing Service (CPNS)
- Psychological Therapies Service (PTS)

[2] Child and Adolescent Mental Health Services (CAMHS) are managed by Child Health

- Substance Misuse and Recovery Service (SMRS)
- Dementia Service (DS)
- Community Mental Health Support Service (CMHSS)

Funding and Resources

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Mental Health	47.44	2,511,616	98,264	2,413,352	44,630

Needs/Unmet needs/Drivers for change

Needs[3]

There is limited data on the actual prevalence and incidence of mental health problems and mental illness in Shetland, though GP practices hold registers of patients with serious mental illness (defined as being schizophrenia, bipolar affective disorder or other psychoses as well as dementia).

The Scottish Mental Health Strategy uses European figures to demonstrate the prevalence of mental health problems in the population. Mental illness is one of the top public health challenges in Europe as measured by prevalence, burden of disease and disability. It is estimated that mental disorders affect more than a third of the population every year, the most common of these being depression and anxiety. Applying that to the Shetland population, it means that out of 15,000 adults aged 15-65, at least 5,000 will experience some form of mental ill health or distress each year. About 1-2% of the population have psychotic disorders (approximately 150-300 adults in Shetland, which fits with the prevalence from GP data). The ageing population is leading to an increase in the number of people with dementia, 5% of people over 65 (approximately 200 in Shetland) and 20% of those over 80 years of age.

In all countries, most mental disorders are more prevalent among those who are most deprived. The prevalence of mental disorders does not appear to be changing significantly over time, though more people are accessing treatment and support as understanding grows and the stigma of mental illness is reducing.

Unmet Needs

The 2014 Mental Health Review highlighted a number of unmet needs and service development requirements including; improving access to evidence based psychological therapies and Clinical/Counselling Psychology, support for Adults with ASD, increased availability of OOH psychiatric emergency services and improvements to the facilities available to support those experiencing a psychiatric emergency.

Drivers for Change

The key drivers of service change and redesign are the Scottish Patient Safety Program for Mental Health, improved support for Carers, a new emphasis on the importance of Personal Outcomes and growing public pressure for mental health services to match the provision and responsiveness of physical care services. The recent Scottish Government “Responding to Distress” initiative and the associated Distress Brief Intervention (DBI) model has also highlighted the potential benefits to patient wellbeing and service effectiveness where frontline healthcare staff are equipped to undertake assessment and signposting of those presenting in distress.. Implementing such a model will require a training initiative that will give a wide range of frontline healthcare staff and Third Sector providers, an increased understanding of mental health conditions.

Scotland’s National Dementia Strategy 2013-2016 outlines the importance of the provision of support following a diagnosis of dementia, both for the person with the diagnosis and for their families and carers. The 5 Pillar Model of post diagnostic support developed by the Scottish

[3] Shetland Mental Health Strategy 2014-2024

Government and Alzheimer Scotland http://www.alzscot.org/campaigning/five_pillars highlights the key areas that are crucial in delivering this support. Although all five pillars are equally important, the areas that have been found to be especially beneficial are 'Supporting Community Connections' and 'Peer Support'.

People living with dementia need to maintain their links with their own communities and continue to be involved in activities within their communities that help them to maintain their independence as long as possible. The opportunity to meet with other people living with dementia has been shown to be beneficial to a number of people following their diagnosis and helps reduce the stigma that is often associated with dementia. It is equally important that carers of people living with dementia have opportunities to meet with other carers with similar needs to share their experience and support each other. To this end it is crucial that provision of care and services are maintained and developed that help to underpin the five pillars and allow people living with dementia and their carers to access the support that is beneficial to them when they require it.

A further driver for change in the delivery of local mental health services will be the Carers (Scotland) Act 2016, which is expected to come into force in 2017 – 2018.

Plans for change
There are a number of changes required to address gaps in provision, ensure the safe and effective delivery of local mental health services and the achievement of agreed strategic objectives. The change programmes are monitored and reviewed via their respective strategy specific Action Plans (e.g. Mental Health, Dementia, Substance Misuse). The headline objectives, some of which are already in progress and others which reamin under review (including the structure and composition of the service), are presented in the following table:

Description	Lead Officer	Start Date	Target Date	Expected Outcome(s) (link to National Outcomes)
Extend the availability and responsiveness of Out of Hours support for psychiatric emergencies	Martin Scholtz	October 2015	March 2017	Improve the safety and quality of patient care; reduce the demand on GBH; fewer beds used in RCH. National Outcomes 3 & 7
Establish a purpose built room in GBH for the management of psychiatric emergencies	Lawson Bissett	April 2016	December 2016	Improve the safety and quality of the patient environment; reduce demand on A&E and Ward 3; improve transfer time to mainland inpatient services. National Outcomes 3 & 7
Increase the range of specialist input routinely available as part of the Multi-Disciplinary CMHT (e.g. Occupational Therapy, Social Work and GP)	Martin Scholtz	April 2016	December 2017	Improve the safety and quality of patient care; make the most effective use of existing resources (e.g. Annsbrae & GP care). National Outcomes 2, 3,4, 5, 8 & 9
Establish a Clinical Psychology Service	David Morgan	Ongoing	October 2016	Fill a clinically significant gap in local service provision; improve the quality and effectiveness of patient care; reduce the number of ECRs to mainland providers. National Outcomes 3, 4 & 7
Redesign psychological therapy services and increase	David Morgan	Ongoing	March 2018	Reduce waiting times; increase the number of locally available

Description	Lead Officer	Start Date	Target Date	Expected Outcome(s) (link to National Outcomes)
local capacity by training a wider range of existing staff				evidence based psychological therapies; improve the resilience and sustainability of psychological therapy services. National Outcomes 3, 4 & 5
Implement the 2015-18 Dementia Strategy Action Plan	Alan Murdoch	Ongoing	March 2018	People living with dementia and their carers will be able to live well with their diagnosis, remaining integrated, within their community, and where possible, within their own home for the rest of their lives. National Outcomes 2, 3 & 4
Relocate the Substance Misuse Recovery Service to premises that will enable it to develop in accordance with the objectives set out in the Shetland Alcohol and Drug Partnership Delivery Plan	Lawson Bissett	April 2016	December 2017	Safe and appropriate premises for the delivery of drug and alcohol services; patients have a positive experience of the service and their dignity is respected; staff are supported to continuously improve the care and treatment they provide. National Outcomes 3, 4, 5, 7, 8 & 9
Establish and develop local capacity to provide training, formal diagnosis and support for adult ASD	Martin Scholtz	April 2016	March 2017	Fill a clinically significant gap in local service provision; improve the quality and effectiveness of patient care; reduce the number of ECRs to mainland providers; enhance the resilience and sustainability of local ASD services. National Outcomes 1, 3, 4 & 5
Implement the 2 stage Distress Brief Intervention (DBI) model for people who present in distress	David Morgan	April 2016	March 2018	Improve the safety and quality of patient care; reduce the number of mental health related presentations and admissions to GBH. National Outcomes 2, 3, 4 & 7
Introduce role appropriate “Equal Partners in Care” (EPiC) training for all staff	David Morgan	April 2016	March 2018	Carers are free from disadvantage or discrimination related to their caring role; Carers are recognised and valued as equal partners in care. National Outcomes 3, 5 & 6
Establish a person centred Consultation & Engagement Framework (inc a Mental Health Website) to facilitate Co-Production	David Morgan	Ongoing	March 2017	People will have easy access to the information they need to become equal partners in the design, delivery and evaluation of local mental health services; departmental governance structures will be remodelled to support Patient and Carer

Description	Lead Officer	Start Date	Target Date	Expected Outcome(s) (link to National Outcomes)
				participation. National Outcomes 1, 3, 4, 8 & 9

Two high profile Scottish Government mental health initiatives have shaped, and will continue to influence, the change plans highlighted above. These are: the extension of the Scottish Patient Safety Programme for Mental Health to Community Mental Health Services and a new four year Mental Health Access Improvement Programme. The aim of these initiatives is to ensure all mental health services are safe, efficient and effective so that people can access high quality mental health services in a timely way.

Key Risks to Delivery

There is a national increase in the demand for, and public expectation of, mental health services. The pace and scale of change in this area of service provision presents a significant challenge in a small, remote and rural setting. Although there has been increased government funding for mental health it remains unclear if this will be sufficient to meet the growth in demand. Mainland services are meeting this challenge by enhancing community provision and resourcing the changing focus by disinvesting from inpatient facilities. In the absence of such facilities in Shetland, local services will need to develop capacity in different ways if they are to meet those expectations and deliver safe and sustainable services. The timely redesign of mental health services requires a resilient workforce with knowledge and skills aligned to the emerging models of delivery. The pace and scale of change, coupled with increased demand, has limited the time available for staff training and increased levels of workplace stress. The risks to delivery will be managed by the strategic allocation of available resources and the redesign of services to achieve maximum efficiency and effectiveness. This outcome will be achieved by patients, carers, staff and the Third Sector working in partnership.

Performance Targets with links to National Outcomes

Measure	Outcome
Psychological Therapy HEAT Target	90% of people requiring a psychological therapy intervention will commence treatment within 18 weeks of referral. National Outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of service users.
Dementia Diagnosis Standard	The number of dementia diagnoses exceeds 50% of prevalence. National Outcome 2: People, including those with disabilities, long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
Dementia Post Diagnostic Support	All people newly diagnosed with dementia will have a minimum of a year's worth of post-diagnostic support. National Outcome 6: People who provide unpaid care are supported to reduce the potential impact of their caring role on their own health and wellbeing.
Off Island Mental Health Activity	The level of “off island” mental health activity will be reduced; fewer people will travel “South” to receive the services they need. National Outcome 9: Resources are used effectively in the provision of health and social care services, without waste.

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Further Reading
The Mental Health (Care and Treatment) (Scotland) Act 2003:
http://www.legislation.gov.uk/asp/2003/13/contents

Mental Health Strategy for Scotland: 2012-2015: http://www.gov.scot/Publications/2012/08/9714
Shetland Mental Health Strategy:
http://www.shb.scot.nhs.uk/board/planning/MentalHealthStrategy20142024.pdf

Scottish Patient Safety Programme for Mental Health:
http://www.scottishpatientsafetyprogramme.scot.nhs.uk/programmes/mental-health

"The Matrix" (NES): http://www.nes.scot.nhs.uk/media/3325612/matrix_part_1.pdf

Shetland Drug and Alcohol Strategy: http://www.healthyshetland.com/resources

Responding to Distress – DBI: http://www.chrysm-associates.co.uk/images/DBIpaper8may15.pdf

Equal Partners in Care: http://www.knowledge.scot.nhs.uk/home/portals-and-topics/equal-partners-in-care/about-equal-partners-in-care.aspx

Carers (Scotland) Act 2016: http://www.gov.scot/Topics/Health/Support-Social-Care/Unpaid-Carers/CarersBill

3.10 Oral Health

Policy context
The Scottish Government expects the overwhelming majority of primary dental care to be provided through independent NHS dental practices, with a Public Dental Service (PDS) meeting any shortfall in provision. A range of specialist dental services is expected to be available to provide treatment that is deemed beyond what would be expected of a primary care dentist, or is not suitable to be provided within a primary care setting.

According to the Scottish Government the remit of the Public Dental Service, is to:

- provide care for people with special needs, including people who would have difficulties accessing general dental practices
- complement the current General Dental Service and specialist services if insufficient, especially in remote and rural areas
- have a public health role, and oral health promotion targeted both at populations and individuals
- assess and treat people referred for specialised and specialist services, including the use of sedation and general anaesthesia.

Current Services
For the last five years Shetland has had no local independent NHS dental practices, and the PDS has been providing primary dental care to the whole population in addition to its more targeted/ specialist remits.

A new independent NHS dental practice opened in Lerwick in January 2016, with the capacity to register 6000 people for NHS primary dental care.

The PDS will continue to provide:

Planned Care - Routine clinical primary care dental services for people who are registered with the PDS for dental care. Even with a new NHS Dental Practice open, planned care will continue to be a major part of current PDS services. Even if several more NHS dental practices were to open throughout Shetland, the PDS would continue to provide its remit of planned care for people with special/additional needs.

Unscheduled Care - Emergency clinical primary care dental services for the whole population, irrespective of whether they are registered with a local dental service or not

Children Services - The dental input required for Childsmile and the National Dental Inspection Programme, as well as routine clinical dental care for children registered with the PDS

Older People - Providing Dental Screening and oral health promotion in Care Homes, as well as routine dental care for older people, in clinics and in homely settings

Visiting Consultants from NHS Grampian provide Specialist oral health care services for the whole population – for orthodontics and oral & maxillo-facial surgery in particular.

The Oral Health Promotion team provides a range of dental public health activities for the whole population, including Childsmile activities in clinics, schools, and other community settings and provides Oral Health education to groups and individuals

Although it is anticipated that the PDS will be able to change towards a greater emphasis on providing local Specialist services eventually, this cannot occur until the number of independent NHS dentists working in Shetland increases substantially.

Funding and Resources

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Oral Health	65.63	3,335,363	212,678	3,122,685	TBC

Plans for change

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
Refresh Oral Health Strategy for 2015-20, with fresh Action Plan	Dental Director	June 2016	Outcomes 1 - 9
Encourage independent NHS dental practices to open in Shetland	Dental Director	Ongoing	Outcomes 1, 3, 4, 5, 6, 7, 8, & 9
Continue developing referral protocols for use by local practices	Dental Director	Ongoing	Outcomes 1, 3, 4, 5, 8 & 9
Initial review of local oral health care for people with Special/ additional needs	Dental Director	3/2017	Outcomes 1-9
Review access to specialist oral health care fo population in need	Dental Director	3/2017	Outcomes 1-9
Develop information sharing with local dental practices to maximise effectiveness of Childsmile outputs	Dental Director	9/2017	Outcomes 1, 3, 4, 5, 8 & 9

Key Risks to Delivery

Risks	Mitigation
The shortfall in primary dental care capacity – both the infrastructure (dental surgeries) and the staff - dentists/ other dental care professionals	The national Scottish Dental Access Initiative is focused to encourage independent NHS dental practices to open in Shetland.
Reduction in central funding for Public Dental Services before assessment of clinical outcomes of new independent NHS practices	None
The geographical isolation of remote, rural and island communities, challenges the cost-efficient provision of oral health care.	Collaboration with regional partners
The increasing number of elderly people requiring domiciliary visits for high-maintenance dental care of their own teeth.	By increasing oral health promotion targeted at adults, to improve the oral health of the population prior to people becoming frail.
The ability to recruit and retain suitably experienced dentists to build sustainable, long-term dental services for Shetland residents.	By building/using managed clinical networks in North of Scotland, to provide specialist clinical leadership and reduce clinical isolation.
The difficulty in providing post-graduate training opportunities for existing dentists, coupled by a lack of resources for post-qualification opportunities for other Dental Care Professionals	The Oral Health Strategy under development will identify what local specialities need to be prioritised.

Performance Targets with links to National Outcomes

Performance Measure	Outcomes
Decay experience of children in P1: The mean dmft (decayed, missing or filled teeth per child) of children aged 5-6 years in P1 attending SIC primary schools	Outcome 1 - People are able to look after and improve their own health and wellbeing and live in good health for longer
Number of people with access to Occasional NHS treatment who are waiting to register with PDS for Continuing Care	Outcome 4 - Health and social care services are centred on helping to maintain or improve the quality of life of service users
The percentage of the adult and child populations who are registered with Shetland dentists for NHS dental care	Outcome 5 - Health and social care services contribute to reducing health inequalities
The ratio of FTE primary care dentists providing NHS oral health care to the total resident population of Shetland	Outcome 9 - Resources are used effectively in the provision of health and social care services, without waste

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3.11 Pharmacy & Prescribing

Policy context
The Scottish Government document "Prescription for Excellence" builds on the Government's 2020 Vision Route Map and Quality Strategy Ambitions. It recognises pharmacists as experts in the therapeutic use of medicines and highlights their potential contribution through integration into health and social care teams.

Over the next few years significant changes will occur in medicine and therapeutics. These changes necessitate the development of new and innovative models of care to enable patients to obtain the maximum benefit. Pharmacists will have a key role in this. Pharmaceutical care is a key component of safe and effective healthcare. It involves a model of pharmacy practice which requires pharmacists to work in partnership with patients and other health and social care professionals to obtain optimal outcomes with medicines and reduce the likelihood of adverse events. Increasingly, there is a need to work across regions and to ensure that governance arrangements accompany patients on their care journey.

These aspirations will result in clinical pharmacist independent prescribers working in collaborative partnerships with medical practitioners An early and key task in Shetland is the review of medicines to ensure that each medicine still provide benefit. This approach is detailed in the national strategy for polypharmacy.

The NHS continues to face increasing workforce pressures. The inclusion of NHS accredited clinical pharmacists into the primary care team is intended to increase the clinical capacity and assist in addressing the growing demands in primary care, particularly as our population in Shetland ages, and the complexity of their care increases.

Current Services
The department has been in place since 1998 it has steadily grown since then and for the first time in 2012 has sufficient staffing to provide a service rather than an input. The service is now within the Health and Social Care directorate following the decision by the council and Health Board to jointly appoint a director of Community health and Social Care in February 2014. The Pharmacy service is overseen by the Director of Pharmacy who has joint responsibility for NHS Orkney.

Pharmacy services
The pharmacy service is integrated both between Primary and Secondary Care and within Health and Social Care, and is adapting to a locality led service. People are at the heart of pharmacy services and Prescription for Excellence envisages patients linking and registering with a particular pharmacist who will support them in managing their medicines wherever they are, at home, in a care setting or in hospital. The developing service is being designed around the patient's needs aspirations and views, and will enable the pharmacist with the patient to draw on help from specialist pharmacists when required. Community pharmacies will increasingly be used as a single point of access to health care.

The pharmacy service will prioritise the national health and wellbeing outcomes through ensuring that people are enabled able to look after and improve their own health and wellbeing and live in good health for longer, through providing better access and tailored support.

Pharmacy services are particularly designed for people, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community. With medicine management support and polypharmacy reviews being provided wherever people live. And when people use , in particular, social care services the aim is for those have positive experiences of those services, and have their dignity respected through supporting patients in taking their medicines through which are designed around the needs and wishes of patients in a way that preserves their involvement, choices and dignity.

Again, and in line with the national health and wellbeing outcomes the national patient safety programme is being implemented with the aim of ensuring that people being prescribed medicines within health and social care services are safe from harm. (national outcome 7) Part of this is around ensuring that people who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

Ensuring that resources are used effectively and efficiently in the provision of health and social care services is both a national and local priority. (National Outcome 9).

As the roles of pharmacists as independent clinicians continues to become imbedded the need to ensure that these activities operate within a quality assurance framework becomes increasingly important.

Funding and Resources

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Pharmacy & Prescribing	10.08	6,300,885	125,004	6,175,881	200,000

Needs/Unmet needs/Drivers for change
Recent reviews of the Out of Hours primary Care arrangement has identified roles for pharmacists identified in this plan. The need for pharmaceutical care is outlined in Prescription for Excellence. Local need is identified through referral, pharmaceutical care planning and data obtained through PIS and SPPARRA data. There are many patients in Shetland who require support in managing their medicines in their own homes. Of these there are a growing number of patients who require medicine (polypharmacy) reviews.

Plans for change
Plans continue to develop the role of pharmacy in an incremental way as outlined in the pharmacy work plan; “creating pharmacy capacity” is required to ensure that Prescription for Excellence is delivered locally. Delivery of the plan will involve recruiting a sustainable workforce, this additional staffing commitment will ensure that polypharmacy work will increase, and that the GP workforce will be supported to ensure a more efficient use of GP time, additional resources through Primary Care funding has also been made available to develop pharmacists into clinical roles within GP practices Supporting Social Care Workers and patients in their own homes will help to reduce medicine waste, and supporting GP practices in improving repeat prescribing should also help too contain medicine cost. Both these interventions will also reduce the risk to patients of harm from there medicines.

In summary the plans for 2016-17 are to

- Recruit an additional pharmacist/technician to the workforce
- Build a quality framework to ensure performance, governance and risk management are part of everyday work
- Increase the availability of support to patients in their own homes and in Care homes
- Continue to develop a training and support programme for Remote and Rural pharmacists
- Work towards meeting the efficiency challenge of £200,000 through implementing a range of savings work in line with the National Effective Prescribing.

Key Risks to Delivery
Recruitment and retention of pharmacists is problematic, and to ensure a sustainable service a remote and rural fellowship is further developed which will build on the success in 2015-16 to to train and develop the skillset of pharmacists locally. Where clinicians are not engaged with the programme then this would also represent a risk to delivery And steps are being put in place, through joint training and information sessions and agreements to mitigate the risk.

Performance Targets with links to National Outcomes
Prescribing Performance reports are produced quarterly and the following Key Performance indicators are in place

Performance Measure	Latest Performance 2015/16 (last year)	Target 2016/17
Cost per patient (GP Prescribing) should be less than Scottish average i.e. less than 100% (national outcome 9)	98%	100%
Number of prescriptions for antibiotics per 1000 patient population should be less than the Scottish average i.e less than 100% (national outcome 7)	114%	95%
Number of polypharmacy reviews completed per month (national outcome 7)	22	40
Percentage of patients who's medicines are reconciled within 72 hours of admission per month (national outcome 7)	58%	75%
Number of discharge prescriptions dispensed out of hours by nursing staff should be less than 50 per month (national outcome 7)	31	48

Contact Details
The pharmacy department can be contacted on 743370.
Director of Pharmacy is Chris Nicolson at christophernicolson@nhs.net

Further Reading
The pharmacy and prescribing services has pages on the NHS website.

National Polypharmacy guidance describes the national context for planned pharmacy work within the context of the national Pharmacy vision and work plan, Prescription for Excellence.

3.12 Primary Care

Policy context

- Integration of health and social care and implementation of Health and Wellbeing Outcomes.
- Introduction of a new GP contract in April 2017
- Primary Care strategy (agreed at IJB in April 2016)
- National Out of Hours review

Primary health care services will be required to adapt to meet the health care needs of an ageing population that has rising expectations of health care and treatments. Other factors that affect the development of services include statutory guidance on working hours, rising professional standards and a shortage of health care professionals.

The key drivers for looking at how primary care operates are:

- We want to improve the health of the people in Shetland and ensure healthcare services are meeting public expectation;
- There is greater demand on local health services in part due to an aging population, with greater health needs;
- A hospital setting is not always the answer; more care can be delivered in primary care and community settings than ever before and patients benefit from care provided closer to their home;
- There are workforce challenges (for example recruitment of GPs) which currently affect delivery of the best quality care and optimal patient outcomes;
- We need to adopt new models of care and best practice which can deliver better health outcomes for patients;
- We want to ensure care is safe, effective, efficient and patient centred.

Current Services

Traditionally, the “four pillars” of Primary Care have been GP Services, Pharmacy Services, Dental Services and Ophthalmic Services. There are separate dental and pharmacy departments in Shetland and these are therefore not covered in this section.

For GP Services, there are currently ten Health Centres in Shetland, together with five non-doctor islands which are staffed by Community Nurses and who receive GP services from a local health centre. Of the ten GP Practices, three are directly salaried to NHS Shetland (all staff are employed by NHS Shetland) and the other seven are what is known as independent practices – this means they contract with NHS Shetland to provide core GP services to their practice population, for which they receive funding worked out through a national formula and it is the responsibility of the independent GP practice to decide how to use this funding to provide the contracted services. It should be noted that the NHS in Scotland will see the introduction of a new GP contract in April 2017, although details on the format of this new contract are still to be released. It is expected that substantial work will be required across Scotland to introduce the new contract and Shetland will be no different in this regard; this is referred to in the actions for 16/17 and this service plan will be updated once the detail of the contract has been negotiated. It is currently expected that information will only be available after summer 2016

Within Ophthalmic services, there are three providers of general ophthalmic services in Lerwick, which are open to all Shetland residents. There are also visiting Ophthalmic Consultants who hold clinics in Gilbert Bain Hospital for patients referred to them with complex eye problems. NHS Shetland contracts with NHS Grampian for the provision of an Optometry Advisor role, with the Optometry Advisor undertaking three yearly Ophthalmic Premises inspection visits in conjunction with the local Primary Care Manager, in addition to being a member of the Eyecare Managed Clinical Network. The most recent visits were completed in September 2015.

Funding and Resources
Please note that workforce details for the independent practices are not available and any additional income e.g. dispensing income within independent practices will not be shown below.

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Primary Care	29.51	4,582,271	11,400	4,570,871	310,000

Needs/Unmet needs/Drivers for change
Primary Care has been set a savings target for 2016/17 which includes efficiencies to be generated through improved processes; redesign of workforce and savings which will be identified from the Primary Care Strategy.

Drivers for change:

- There is variation in opening times, different appointment systems and waiting times for appointments between practices;
- There is variation in additional services provided, for example enhanced family planning and minor surgery;
- There are current difficulties with balancing the requirements to provide enough appointments to meet demand within waiting times, with the need to spend sufficient time with patients;
- There are geographical issues, which may influence ease of access;
- There are noticeably different arrangements in hours and out of hours;
- Recruitment and retention has proven to be problematic in recent years, across all Practices in Shetland. It is not unusual for there to be several rounds of advertising and it is becoming more difficult to recruit staff who wish to work in a remote and rural location;
- A changing workforce profile and changing skills set needed for new models of care;
- Changes to secondary care provision in terms of services now being offered through primary care providers rather than the hospital;
- Inequity of funding provision across Primary Care in Shetland;
- Clinical/medical innovations and improvements such as telehealth.

Shetland has submitted bids to the National Recruitment & Retention Fund, as well as working with other remote & rural Boards on a joint bid with a view to promoting the roles and opportunities of remote working and we will continue to seek innovative ways to attract staff to Shetland. Nonetheless, recruitment and retention of staff at all grades remains the greatest risk to delivery.

Plans for change

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
Implement 2016/17 GP Contract and QOF amendments	Lisa Watt	April 2016	All Shetland practices to have a contract based on 15/16 contract and QOF amendments once issued by Scottish Government. (H&WO 1, 2, 3, 4, 5, 6, 7, 8, 9)
Implement agreed actions from Primary Care Strategy. Service Plan will be updated with specific actions once these are agreed	Lisa Watt	April 2016	(H&WO 1, 2, 3, 4, 5, 6, 7, 8, 9)

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
Plan and negotiate for implementation of new GP contract for 2017/18 once the detail has been agreed and notified to Boards. Details of the contract will only be announced in Summer 2016 and there is therefore no further detail to hand at present.	Lisa Watt	April 2016	Smooth implementation for go live date of 1st April 2017, ensuring seamless transition and no disruption to services (H&WO 1, 2, 3, 4, 5, 6, 7, 8, 9)
Implement agreed actions from both local and national Out of Hours reviews once these report at the end of 2015. It has been agreed that this will be under the umbrella of the Out of Hours Working Group, chaired by Roger Diggle	Roger Diggle	April 2016	(H&WO 1, 2, 3, 4, 5, 6, 7, 8, 9)
Continue to support the growth of the Scalloway practice	Lisa Watt	April 2016	Increasing the practice size in Scalloway will help practice viability, as well as ensuring a more even spread of patient numbers across central Shetland. (H&WO 3, 4, 5, 7, 8, 9)
Identify permanent arrangements for Practice Management at the Lerwick Health Centre, utilising the capacity across all salaried practices to support primary care management of services	Lisa Watt	April 2016	Resources are used effectively and efficiently in the provision of health and social care services.
Review the skill mix required in the Lerwick Health Centre following the extension of the ANP model, to ensure efficiency and to identify opportunity for savings	Lisa Watt	April 2016	Resources are used effectively and efficiently in the provision of health and social care services.

Key Risks to Delivery

Risk	Mitigation
GP Recruitment across 5 GP Practices in Shetland	Service redesign including use of Advanced Nurse Practitioners in Lerwick Health Centre. Different types of advertising are being used, including Facebook and attendance at the RCGP conference to promote Shetland as a place to work and live.
Recruitment and retention of staff at all grades	There is low unemployment in Shetland at the moment, which is leading to difficulties in recruitment. Promoting NHS Shetland as a favourable place to work and actively supporting training schemes (such as the GP Training scheme) has benefits to recruiting staff.
Capacity in small Primary care	Under review

Risk	Mitigation
management team required for day to day management and ongoing service redesign	

Performance Targets with links to National Outcomes

Measure	National Outcome
Percentage access to a primary care health professional for on the day requests at any Shetland Health Centre	Outcome 1 - People are able to look after and improve their own health and wellbeing and live in good health for longer
Percentage conversion of OOH GP house visits converting to admission to hospital	Outcome 2 - People, including those with disabilities, long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community

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Further Reading

NHS Shetland 2020 Vision: http://www.shb.scot.nhs.uk/board/planning/2020VisionReport.pdf

3.13 Substance Misuse

Policy context
There are a number of national strategic plans for both alcohol and drugs which underpin the aims of the Shetland Alcohol and Drug 2011 – 2018 strategy;

- Changing Scotland's Relationship with Alcohol a framework for action (2009) Scottish Government,
- The Road to Recovery' (2008) Scottish Government
- Essential Care'(2008) Scottish Government
- Quality Alcohol Treatment and Support Report (2011) Scottish Government
- Review of Opioid Replacement Therapy'(2013) Scottish Government
- Quality Principles' for alcohol and drug services (2013) Scottish Government
- Outcomes Framework for Problem Drug Use

The clear focus is on ensuring that services and interventions delivered are of high quality, are effective and cost effective, and focus on supporting people in recovering from substance misuse.

Substance Misuse impacts on individuals, families and communities. A number of local service providers exist to offer treatment and support to both individuals with their own issues and people who are affected by others misuse.

In Shetland, Alcohol and Drug Services are commissioned through Shetland Alcohol and Drug Partnership (SADP). SADP is a multi agency strategic partnership that meets bi-monthly to oversee the design and development of services.

In addition to SADP the Shetland Alcohol and Drug Forum, a multi agency operational group, also meets bi-monthly. Its aim is to provide SADP with information on operational issues and assist with the planning process.

Current Services
In recent years the main services in Shetland providing help and support to a) people with their own substance misuse issues and b) people affected by those who are misusing substances, have been delivered by a mixture of both voluntary sector and statutory sector services. The new Substance Misuse and Recovery Service (SMRS) is part of the Community Health and Social Care directorate and started operating in April 2015.

Tiers
The Scottish Governments, through its resource allocation, expects all ADPs to provide services under the following Tiers:

Tier 1: Tier 1 interventions include provision of drug-related information and advice, screening and referral to specialised drug treatment.

- Drug & alcohol treatment screening and assessment;
- Referral to specialised drug & alcohol treatment;
- Drug & alcohol advice and information;
- Generic services should also provide their own services to drug misusers and some may be specifically designed for drug misusers (e.g. housing projects for those leaving rehabilitation).

Tier 2: Tier 2 interventions include provision of drug-related information and advice, triage assessment, referral to structured drug treatment, brief psychosocial interventions, harm reduction interventions (including needle exchange) and aftercare;

- Triage assessment and referral for structured drug treatment,
- Drug intervention which **attracts** and **motivates** drug misusers into local treatment systems, including engagement with priority groups, such as pregnant women, offenders and stimulant users,

- Interventions to reduce harm and risk due to BBVs and other infections for active drug users, including dedicated needle exchanges and the support and co-ordination of pharmacy-based needle exchanges,
- Interventions to minimise the risk of overdose and diversion of prescribed drugs, Brief psychosocial interventions for drug and alcohol misuse (including for stimulants and cannabis problems if it does not require structured treatment),
- Brief interventions for specific target groups including high-risk and other priority groups,
- Drug-related support for clients seeking abstinence,
- Drug-related aftercare support for those who have left care-planned structured treatment,
- Liaison and support for generic providers of Tier 1 interventions,
- Outreach services to engage clients into treatment and re-engage people who have dropped out of treatment,
- A range of the above interventions for drug-misusing offenders

Tier 3: Tier 3 interventions include provision of community-based specialised drug assessment and co-ordinated care-planned treatment and drug specialist liaison;

- Comprehensive Substance misuse assessment,
- Care planning, co-ordination and review for all in structured treatment, often with regular keyworking sessions as standard practice,
- Harm reduction activities as integral to care-planned treatment,
- A range of prescribing interventions in the context of a package of care, a range of structured evidence-based psychosocial interventions to assist individuals to make changes in drug and alcohol using behaviours,
- Structured day programme and care-planned day care,
- Liaison services for acute medical and psychiatric health services (i.e. pregnancy, mental health and hepatitis service),
- Liaison service for social care services (i.e. child protection and community care teams, housing, homelessness),
- A range of the above interventions for drug-misusing offenders

Tier 4: Tier 4 interventions include provision of residential specialised drug treatment, which is care planned and care co-ordinated to ensure continuity of care and aftercare.

- Inpatient specialist alcohol and drug assessment, stabilisation and detoxification/assisted withdrawal services;
- A range of alcohol and drug residential rehabilitation units to suit the needs of different service users;
- A range of halfway houses or supportive accommodation for substance misusers; residential alcohol and drug crisis intervention units (in larger urban areas);
- Inpatient detoxification/assisted withdrawal provision, directly attached to residential rehabilitation units for suitable individuals, provision for special groups for which a need is identified (i.e. pregnant women, substance users with liver problems, substance users with severe and enduring mental illness). These interventions may require joint initiatives between specialised substance use services and other specialist inpatient units;
- A range of the above interventions for substance misusing offenders.

Funding and Resources

Funding for Shetland Alcohol and Drugs Services is provided by a Scottish Government Allocation, NHS Shetland and Shetland Islands Council. Funding has been at a consistent level for a number of years. Scottish Government have announced that the level of funding for ADPs for 2016/17 is to reduce.

Reductions in funding will inevitably have an impact on service delivery. SADPs Fund Disbursement Group through mapping of service provision and undertaking needs assessments have recommended the following:

Tier 1 information and awareness provision will continue to be provided by generic and mainstream services, supported by SADPs comprehensive education programme and bespoke training/awareness sessions, early identification and intervention.

Tier 2 provision, specifically non-structured support for individuals with their own substance misuse issues will be provided with the Substance Misuse Recovery Service. Individuals will be provided with pre and post treatment support. Non-structure support for young people will be delivered via the Young Persons Service with the SMRS.

Tier 3 structured treatment and support will be delivered via the Substance Misuse Recovery Service.

Tier 4 will continue to be supported via NHS Shetland and SIC through off island residential placements.

Service	Number of Staff (WTE)	Expenditure	Income	Net Budget	Savings target
Substance Misuse	11.55	869,243	116,486	752,757	TBC

Table of budget and savings targets, including workforce details

Service	Number of Staff (WTE)	Expenditure	Income	Net Budget	Savings target	Service provider
Young person's service (Tiers 1 & 2)	1	£37,000				SMRS
Peer led education programme (Tier 1)	1	£13,000				OPEN Project
Drug education and enforcement service (Tier 1)	2	£27,000				Dogs Against Drugs
Signposting and resource service (Tier 1 & 2)	1	£28,000				Health Improvement/
Employability project (Tier 1 & 2)	2	£39,500				Shetland Community Bike Project
Tier 3 Recovery service (Tier 2 & 3)	9.6	£413,000				SMRS
Off island detox & residential rehabilitation	0	£65,000				NHS & SIC Off Island placements

(Tier 4)						
Shetland Alcohol and Drug Partnership support	1.5	£86,500				NHS

Needs/Unmet needs/Drivers for change
Previous years have seen the development and delivery of a Families Affected by (FAB) service. This has been facilitated through a 3rd Sector provider. The above budget recommendations does not include this provision via the Alcohol and Drugs resource allocation. However, SADP makes recommendations for FAB services to continue via existing generic, mainstream and national service provision i.e.

- Group work – self facilitated, supported by the local Carers Support Worker and National agencies i.e. Scottish Families Affected by (http://www.sfad.org.uk/), Famanon (http://famanon.org.uk/).
- One-to-one support/therapy – self-help i.e. CCBT Beating the Blues, secondary care support via NHS Community Mental Health.
- Ad-hoc specialist advice will still be available to FAB via SMRS and generic, mainstream services.

Plans for change
Appropriate accommodation for the Substance Misuse Recovery Service is currently being sought.

A review of the Young Persons Service will be undertaken quickly to map current provision and ensure any new service will compliment and not duplicate.

Key Risks to Delivery
Workforce/capacity issues mean that other professional staff don't have the time they would like in order to undertake preventative work.

The main risk is the requirement to achieve savings, which makes it harder to 'invest to save' in the way that we would like to do. We are addressing this through the use of volunteers, where at all possible, and think of ways to maximise the contributions of staff that we do have.

Performance Targets with links to National Outcomes
The Core Outcomes for Alcohol and Drug Partnerships in Shetland can be found here:
http://www.gov.scot/Resource/0039/00394539.pdf

a. Shetland Alcohol and Drug Partnership Strategy Outcomes are to:
   - Reduce prevalence of alcohol and drug use in adults by 5% by 2020, through early intervention and prevention;
   - Reduce alcohol and drugs related harm to children and young people;
   - Improve recovery outcomes for Service Users;
   - Reduce drug and/or alcohol/suicide related deaths to 2 or less a year by 2020
b. Local Outcome Improvements under Outcome C: We live longer healthier lives
   - To reduce alcohol consumption as a key risk factor for poor health outcomes; specifically focusing on the most vulnerable and disadvantaged individuals and communities.
c. Public Health Ten Year Plan Targets:
   - To reduce premature mortality (as measured by European age standardised death rates, from all causes, for under 75s). The table illustrates Scotland-wide compared to Shetland rates of premature mortality.

- To reduce the number of alcohol related admissions (discharges) from a baseline of 761/100,000 discharges in 2009/10 to a target of 500 / 100,000 discharges by 2014/15, and 300/100,000 by 2021/22. (This target is based on the best performing Boards in Scotland)

Contact Details
Substance Misuse Recovery Service
Lerwick Health Centre
South Road
Lerwick
Shetland, ZE1 0TB
Tel: 01595 743006

Further Reading
Shetland Alcohol and Drug Partnership Strategy 2016-2020
http://www.healthyshetland.com/resources

Public Health Ten Year Strategy 'Changing the World' (2012-2022)
http://www.shb.scot.nhs.uk/board/planning/Strategy_version_1.4_final.pdf

Outcomes Framework for Problem Drug Use, October 2014, NHS Health Scotland
http://www.healthscotland.com/uploads/documents/24442-Outcomes%20Framework%20for%20Problem%20Drug%20Use..pdf

CEL 01 (2012) Health Promoting Health Service
http://www.sehd.scot.nhs.uk/mels/CEL2012_01.pdf

3.14 Health Improvement

Policy context
External and national drivers for taking a new approach to health improvement include:

- Increasingly challenging national targets (e.g. HEAT target for smoking cessation which is now focussing on the hardest to reach groups)
- Increasing emphasis on doing things 'with' people rather than 'for' them, including using co-production[4], enablement, and asset based[5] approaches
- Fewer public sector resources to meet increased demand due to factors such as changing demographics (the aging population) and global economics. This was the focus of the recent Christie Commission
- Changes in lifestyle and culture (for example more sedentary work and leisure pursuits, and the use of games consoles and portable devices)
- Changes in diet (for example increased consumption of processed and convenience food, and larger portion sizes)
- A persisting, and possibly worsening, inequality gap between the most advantaged and the most disadvantaged in our society

Current Services
There are a range of health improvement services and resources available for people and communities in Shetland, most of which are open access. There are also a number of training programmes, usually for staff and volunteers, but some are also open to members of the public. Many of the services listed below are delivered by the Health Improvement Team, but there are other providers including the voluntary sector, primary care and other NHS departments. Services include:

- '**Help Yourself to Health'** information and resources based in the Shetland public library
- **Keep Well** Health Checks workplaces and primary care
- **Smoking Cessation** Services in primary care; community pharmacies; and drop in sessions
- **Weight Management** including Counterweight in primary care (for adults) and a range of Child and Family healthy weight interventions
- **Drug and Alcohol** services delivered by Community Alcohol & Drug Services Shetland and the NHS prescribing Clinic
- **Sexual Health and Wellbeing** Clinic; a Monday evening drop-in clinic at the Gilbert Bain Hospital
- **A pre-conceptual care** service for people planning pregnancy, which is provided through the maternity department by a specialist midwife.
- **Exercise on referral** as part of cardiac rehabilitation programme (with Shetland Recreational Trust)
- **Falls prevention work** including Chair-Based Exercise
- **Healthy Working Lives**: includes advice, resources and training for employers and workplaces
- **ASIST (Suicide Prevention)** and **Mental Health First Aid training**
- **Improving Health: Developing Effective Practice** Training for healthcare and other workers

Other health improvement activities often delivered in partnership: including awareness raising and campaigns; preventative work (often with children and young people); other training events.

[4] **Co-production is a new vision for public services based on recognising the resources that citizens already have, and delivering services *with* rather than *for* service users, their families and their neighbours.**

[5] Asset based approaches are based on the principles of appreciating and mobilising individual and community talents, skills and assets, rather than focussing on problems and needs

Funding and Resources

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Health Improvement	5.13	315,070	4,581	310,489	TBC

Needs/Unmet needs/Drivers for change

Needs assessment undertaken through locality profiling, and analysis of current service delivery. There is a more detailed assessment of need within the overarching health improvement strategy and within each of the individual health improvement strategies. Key statistics for Shetland include:

- There are still approximately 2500 people who smoke
- According to GP figures, smoking rates are higher in the practices covering the more disadvantaged areas of Shetland
- In 2015 nearly 14% of pregnant women were smoking at booking
- In 2015 27% of primary 1 children in Shetland were overweight or obese (Body Mass Index - BMI on 85th centile or above)
- There were 138 alcohol related stays in hospital during 2015
- One person died through suicide or death of undetermined intent in 2014; this number has reduced from a high of 7 in 2011 and 2012, but might easily rise in future so we should not be complacent.

Whilst there is a wide range of health improvement services and activities available in Shetland, many of these are still centred in Lerwick (e.g. the drop in clinics, community pharmacy services and many of the training events) and people in the more remote and rural areas need better access to the same opportunities.

As well as geographical limitations, there are other restrictions on the services that can be provided because of our very small scale. This can result in widening the health inequalities gap by excluding some of the most vulnerable and disadvantaged groups from being able to access services. There is therefore an unmet need in making health improvement services and activities more accessible to all communities and groups that need them.

There are some specific areas of unmet need that have been identified, and these have not changed in the past year, including:

- Exercise referral for more groups (currently just for cardiac rehabilitation patients).
- Greater range of weight management interventions, particularly for those needing a more intensive intervention than Counterweight.
- Psychological interventions and support for individuals with complex needs struggling with behaviour change.

Plans for change

Description	Lead Officer	Start date/target end date	Expected Outcome(s) (link to National Outcomes)
Increasing capability, capacity and the contribution of non specialist staff: including work with the wider workforce through the Health Promoting Health Service programme to embed health improvement in routine practice; increasing community based work and the use of volunteers. 'invest to save' to support accelerated health improvement programmes tackling key risk factors and positive lifestyles with a focus on physical activity, reductions in smoking and alcohol misuse; utilising the increased capacity and capability as above. Community capacity building and work in partnership with voluntary sector partners.			

Key Risks to Delivery
Workforce/capacity issues mean that other professional staff do not have the time they would like in order to undertake preventative work.

The main risk is the requirement to achieve savings, which makes it harder to 'invest to save' in the way that we would like to do. There has been a reduction of 7.5% in the 'prevention bundle' from government that was previously used to fund health improvement, and the funding now given is no longer ringfenced. We are addressing this through the use of volunteers, where at all possible, and finding ways to maximise the contributions of staff that we do have.

Performance Targets with links to National Outcomes
Shetland Partnership Outcomes

Outcome A: Shetland is the best place for children and young people to grow up
Priority: To support children and young people to develop physical competence and confidence from the earliest age
Actions: Support pre-school years to reach daily targets for physical activity by encouraging active play, and active travel at home and in care settings
Support active schools and partners to engage all school aged children in sports and physical activity including targeting those most in need

Outcome B: We live longer healthier lives and people are supported to be active and independent throughout adulthood and in older age
Priority: Increase physical activity among those least active
Actions: We will encourage and enable the inactive to be more active and we will encourage and enable the active to stay active throughout life through the development of a local Sport, Physical Activity and Health Strategy, which will include:

- Improving our active infrastructure – people (e.g. volunteering capacity) and places (e.g. footpaths and indoor and outdoor facilities)

- Building on localities based models, including Sports Hubs and health improvement locality working, to increase physical activity; targeting those who most benefit (e.g. walking groups and chair-based exercise for older people; decrease costs and barriers to sport and leisure activities for poorer families
- Improving opportunities to participate, progress and achieve in physical activity including sport
- Using 'return on investment' work to inform the development of the strategy.

Priority: Improve mental health and resilience
Actions: We will support individuals to be part of their community, to reduce lonliness and increase community connectedness
We will support wellbeing and resilience in communities through physical activity and sport (as above)

Priority: People are the key assets in their communities:
Actions: We will support individuals to be part of their community, to reduce loneliness and increase community connectedness
We will develop self-management capacity and resources within the community; for people with long-term conditions, older people and other vulnerable groups.

Outcome C: Shetland stays a safe place to live, and we have strong, resilient and supportive communities
Priority: Reduce the harm caused by alcohol
Actions: Reduce the harm caused by alcohol through the delivery of the Shetland Alcohol and Drugs Partnership strategic plan
Refresh and deliver Drink Better Strategy and action plan
Work with licensees and vendors, supporting and empowering them to refuse alcohol to drunk customers
Peer Education with Young people including input from Police and Youth Volunteers

Indicator (s) – linked to priorities				
Priority	**Indicator**	**Baseline (with date)**	**2020 Target**	**Update Schedule**
Physical activity	Physical Activity Levels	41% in 2011	50% by 2022	Annual
Reduce the harm caused by alcohol	No. of alcohol related A&E attendances	706 (2014/15)	Decrease by 20%	Annual data
	No. of problem drinkers	12.2% (2014/15)	10%	Annual data

Indicators – related to outcome			
Indicator	**Baseline (with date)**	**2020 Target**	**Update Schedule**
% of children at P1 check at risk of overweight or obesity	19.3 (08/09) 22.6 (09/10) 21.8 (10/11) 23.4 (11/12) 21.2 (12/13) 17.9 (13/14) 27.1 (14/15)	12% at P1 check at risk of overweight.	Annual
Smoking prevalence : reduce percentage of adults who smoke	22.4% in 2012	5% by 2022	Annual in Sept

Indicator	Baseline (with date)	2020 Target	Update Schedule
Alcohol related hospital admissions	477/100K (2014)	300/100K	Annual
Reduce premature mortality (from CHD among under 75s)	63.9 per 100,000 in 2013*	64.7 per 100,00 European Age Standardised rate	Annually in Jan

Public Health Ten Year Plan Targets:

- To reduce premature mortality (as measured by European age standardised death rates, from all causes, for under 75s).
- To redue the percentage of adults who smoke from 15% in 2010 (as measured by Scottish Household Survey) to 10% by 2015, and 5% by 2022
- To achieve the HEAT target of 40 inequalities related smoking cessation successful quits at 12 weeks by end March 2017
- To reduce the number of alcohol related admissions (discharges) from a baseline of 761/100,000 discharges in 2009/10 to a target of 500 / 100,000 discharges by 2014/15, and 300/100,000 by 2021/22. (This target is based on the best performing Boards in Scotland)

Contact Details
Health Improvement are based at Grantfield, Lerwick, Shetland ZE1 0NT
Phone: 01595 807484
Email: shet-hb.healthimprovementdepartment@nhs.net

Further Reading
- Public Health Ten Year Strategy 'Changing the World' (2012-2022) http://www.shb.scot.nhs.uk/board/planning/Strategy_version_1.4_final.pdf
- NHS Shetland Public Health Ten Year Strategy 'Changing the World' Update August 2014 'More than Targets'
- Mental Health Strategy
- Obesity Strategy
- Active Lives Strategy
- Shetland Sports Strategy
- Choose Life Action Plan
- Older People's Strategy
- CEL 01 (2012) Health Promoting Health Service letter and Health Promoting Health Service CMO letter (2015) 19

3.15 Nutrition and Dietetics

Policy context
SIGN, NICE, British Dietetic Association, HPC, BAPEN, NHS Shetland Guidelines and Policies, Diabetes UK.

Current Services
The main areas of practice are Diabetes Type 1 and 2, Gestational, Gastro Intestinal and Weight Management, Cancer, Weight loss, some eating disorders, Gastrostomies, PEG feeds, Nasogastric feeds and increased protein requirements. The dietetic service also has a responsibility to ensure MUST and other nutrition training is in place for care home and care at home staff and to deliver staff and patient education on all the areas listed above.

Dietetic services are provided at 3 in-patient wards in the Gilbert Bain Hospital, out-patient clinics at the Gilbert Bain Hospital, Care Homes, through telephone appointments and domiciliary visits where there is assessed need.

Funding and Resources

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Nutrition and dietetics service	3.00	118,162	6,479	111,683	TBC

Needs/Unmet needs/Drivers for change
The dietetic service is in a vulnerable position having had a high turnover of staff in the last few years. It is currently undergoing significant development to ensure it is meeting the needs of the population of Shetland, however this development is challenged by a current vacancy.

The particular areas requiring further development and consolidation are described in the plans for change section.

Plans for change

Description	Lead Officer	Start date/target end date	Expected Outcome(s) (link to National Outcomes)
Complete Development and implementation of bariatric pathway	Lead dietician	Underway	People are able to look after and improve their own health and wellbeing and live in good health for longer
Complete development of and implement general Weight Management plan, and roll out sessions in specific Health Centres	Lead dietician	Underway	People are able to look after and improve their own health and wellbeing and live in good health for longer
Complete development of diabetes pathway and roll out as appropriate	Lead dietician	Underway	People are able to look after and improve their own health and wellbeing and live in good health for longer
Complete and evaluate pilot training programme to care homes and roll out across care home estate	Lead dietician	Underway	People using health and social care services are safe from harm
Design web page on the Dietetic service including referral criteria and pathways	Lead dietician	April 2016	Resources are used effectively and efficiently in the provision of health and

Description	Lead Officer	Start date/target end date	Expected Outcome(s) (link to National Outcomes)
for all referring clinicians.			social care services

Key Risks to Delivery

Risk	Mitigation
Reduction in dietetic time will mean that only urgent cases will be seen meaning that less preventative work is undertaken	Cases will be prioritised, however risk remains that a single dietician will be unable to manage even high priority cases
Unable to obtain approval to recruit to vacant dietetic post	Case will be made to EMT to recruit to vacant positions
Positions prove unattractive to potential applicants due to fragility of service meaning posts remain unfilled.	Attempts will be made to ensure stability of service

Performance Targets with links to National Outcomes

Performance target	National outcome
18 Week RTT	Resources are used effectively and efficiently in the provision of health and social care services

Contact Details
Dietetic Service
Breiwick House
Tel: (01595) 743203

3.16 Occupational Therapy

Policy context
The development of Occupational Therapy services is informed by key government strategies. These include but are not limited to the Principles for Planning and Delivering Integrated Health and Social Care, the National Health and Wellbeing Outcomes, Scotland's National Dementia Strategy, the Delivery Framework for Adult Rehabilitation in Scotland, and Realising Potential, An Action Plan for Allied Health Professionals working in Mental Health Services.

The See Hear Strategy guides the development of our sensory impairment services.
The AHP National Delivery Plan is currently under review which will identify key actions for our service.

The legislative framework behind our role along with NHS and SIC current strategies and priorities also influence the occupational therapy service priorities and development.

Current Services
Occupational therapy is the use of functional assessment and treatment to develop, recover, or maintain the daily living and role skills of people with a physical, sensory, mental, or cognitive disorder. Occupational therapy is a client-centered practice that places emphasis on the progress towards the client's goals. We identify and eliminate environmental barriers to independence and participation in daily activities. We work closely with members of any multi disciplinary team and with community services.

GBH: Occupational therapy assessment, rehabilitation, treatment, advice and information enabling both in and out patients to adapt to impairment and return to their valued activities and occupations, their home and their community.

SIC: Community based occupational therapy enabling disabled, and older people to remain at home for as long as possible. Assessment, functional rehabilitation, advice and information are provided. Home adaptations and specialised equipment support these processes. People with sensory loss also access these services.

SIC Telecare: Technology is utilised to enable vulnerable people to live independently and securely in their home through a range of electronic monitoring equipment. These options provide real choices other than residential care.

SIC Independent Living Centre: A community resource with information and a selection of equipment for the public to view and trial. The Blue Badge Clinic is run from this facility.

SIC Equipment Store: Manages, maintains, delivers, installs, collects, and repairs all occupational therapy equipment used in the community. The Community Nursing store is also located here.

Funding and Resources

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Occupational Therapy	20.91	1,590,582	34,582	1,556,000	TBC

Needs/Unmet needs/Drivers for change
Needs/Unmet needs include:

- Mental health occupational therapy services. The Mental Health Strategy for Scotland identifies that mental illness is one of the top public health challenges as measured by prevalence, burden of disease and disability. It is estimated that mental disorders affect more than a third of the population every year, the most common of these being depression and

anxiety. With team members, occupational therapists emphasise and support a person's potential using the Recovery model to guide practice.

- Scotland's National Dementia Strategy identifies the need for improved services following diagnosis by providing excellent support and information to people with dementia and carers. There is a need for specialist occupational therapy knowledge and championing of occupational therapy as an integral part of dementia services
- Neurological outpatient occupational therapy assessment and treatment to maximise people's potential once discharged from hospital to maximise outcomes.
- A&E would be advantaged by a rapid response service to facilitate discharge directly home wherever possible, rather than a ward admission.

Drivers for change include:

- New and updated Government strategies
- The growing and aging population
- The expectation that aging, and disabled people will remain at home whenever possible
- The increasing role that carers of all ages will play in supporting aging and disabled people to remain at home
- The expanding possibilities of Telecare
- The need to develop a consistent best practice model of practice across all Localities with a focus on early integrated interventions
- The possibilities of electronic working (eHealth)

Plans for change

Description	Lead Officer	Start date/target end date	Expected Outcome(s) (link to National Outcomes)
Explore need for dedicated Mental Health OT service and implement as appropriate	Jane Pembroke	April 2016 onwards	1-People improve their health and well being 2- people can live at home 3- positive experience 4 – quality of life 6-unpaid carers are supported 9 effective resource utilisation
Explore need for specialisation in Dementia services and implement as appropriate Work with existing services to support and enable carers	Jane Pembroke	April 2016 onwards	1-People improve their health and well being 2- people can live at home 3- positive experience 4 – quality of life 6-unpaid carers are supported 9 effective resource utilisation
Increase number of people in receipt of technology enabled care	Jane Pembroke	April 2016 onwards	1-People improve their health and well being 2- people can live at home 3- positive experience 4 – quality of life 9 effective resource utilisation

Description	Lead Officer	Start date/target end date	Expected Outcome(s) (link to National Outcomes)
Provide rapid response to A&E in order to facilitate discharge straight home	Jane Pembroke	April 2016 onwards	2- people able to live at home 4 -quality of life 6-unpaid carers are supported 8- staff are supported to feel engaged and continuously improve their service 9- use resources effectively and efficiently
Continue to explore ways to properly integrate the two OT services to provide a constant and seamless service to GBH and the community	Jane Pembroke with Jo Robinson	Commenced April 2015, ongoing development	1-People improve their health and well being 2- people can live at home 3- positive experience 4 – quality of life 9 -resource are used effectively
ILC Equipment Store- review, and refresh all procedures and protocol that ensure the supply of appropriately maintained equipment. Integrate district nursing equipment into establish integrated system.	Jane Pembroke/ Ian Sandilands	October 2015 and ongoing	3- people have positive experience of our service 7 -people who use our service are safe from harm 9- resources are used effectively

Key Risks to Delivery

Risk	Mitigation
Lack of staff resource to implement and maintain quality initiatives	Self assessment and self management techniques are implemented wherever possible to do so safely
Recruitment to hospital posts continues to present challenges	Continued redesign to ensure posts are varied and satisfying
Poor management and deployment of equipment due to competing pressures	Ensure risks assessments, protocols and procedures are in place and implementation monitored
Large geographical area and increasing need to provide wider range of services, to respond to a wide variety of government and professional initiatives	Continued redesign of services to ensure most effective and efficient use of resources
Potential conflict between needs of health board and statutory responsibilities of local authority within limited resources	Ensure prioritisation of needs of both services and potential conflicts are raised with managers

Risk	Mitigation
Need for staff to have wide ranging generalist and specialist skills	Ensure personal development plans are up to date and CPD opportunities are taken. Ensure quality control mechanisms are in place

Performance Targets with links to National Outcomes

Performance target	National Outcome
National Eligibility Criteria timescales	NHWO 2
Increasing number of people are supported by technology enabled care	NHWO 1,2, 7

Contact Details

Occupational Therapy Service, Independent Living Centre, Gremista 01595 744319
Occupational Therapy Service, Gilbert Bain Hospital 01595 743022

Further Reading

- Principles for Planning and Delivering Integrated Health and Social Care http://www.gov.scot/Resource/0046/00466005.pdf
- National Health and Wellbeing Outcomes Framework
- Scotland's National Dementia Strategy 2013-2016
- Co-ordinated, integrated and fit for purpose: A Delivery Framework for Adult Rehabilitation in Scotland
- Realising Potential, An Action Plan for Allied Health Professionals - Bing
- Social Work (Scotland) Act 1968
- Chronically Sick & Disabled Persons Act 1972 - Bing
- Health and Safety at Work etc. Act 1974;
- Disability Discrimination Act 2005
- Housing (Scotland) Act 2006
- Occupational therapy information Live life your way | BAOT/COT

3.17 Orthotics

Policy context
The main policy context for Orthotics is the Allied Health Profession's National Delivery Plan. This emphasises the requirement for people with musculoskeletal problems to be treated within four weeks of receipt of referral. In addition, the works within the integration framework and therefore aims to achieve the nine Health and Wellbeing Outcomes and national indicators.

Current Services
The Orthotic Department provides Orthotic services to NHS Shetland and the local community. The Orthotic service is multifunctional with diagnostic and treatment services for people with Musculoskeletal (MSK) issues. It is aimed at, avoiding pain, returning function, preventing deformity and protect "at risk" body parts. This is achieved using Orthotic devices and/or advice on self help. The department's aim is to keep patient's mobile and pain free. This can be achieved by working closely with community services to keep patients in their home environment for as long as possible or to help patients return to work earlier via appropriate interventions. The service also holds the budget for Breast prostheses services, Wig services and is involved in the wheelchair services in Shetland.

With integration embedding itself, it is planned that Orthotic Services technical side will be able to prevent wastage by servicing and repairing community seating equipment.

Funding and Resources

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Orthotics	2.00	143,363	0	143,363	0

Needs/Unmet needs/Drivers for change
There will be an increasing need for Orthotic services with an aging population requiring increased support for mobility to keep them safe (e.g. avoiding falls) and in their home environment. With this comes a need for further protection to prevent pressure injuries which are expensive to heal both in nursing time and dressings.

There is currently an Orthotic service redesign plan submitted to move the service to the Independent Living Centre. This move is part of the Ambulatory Care Service changes being developed with acute services at the Gilbert Bain Hospital. This will include a move to new clinical and technical technology which will release time to improve the service (improving the patient experience) and also to be close to and responsive to community services so that equipment can be serviced rather than disposed off as is currently the case.

Plans for change

Description	Lead Officer	Start date/target end date	Expected Outcome(s) (link to National Outcomes)
Overseeing the departments move to the Independent Living Centre (ILC), as part of the Ambulatory service redesign. Introduction of new technologies which will improve service delivery times and release time for service improvement.	Laurence Hughes	July 2017	Improved service integration between Orthotic services and community services. H&WB 3 improving patient experience. H&WB9. Resources are used effectively and efficiently.

Description	Lead Officer	Start date/target end date	Expected Outcome(s) (link to National Outcomes)
Increase speed of treatment by moving to modern treatment techniques. This will allow patients from outer lying islands to be treated on the same day and avoid a return visit.	Laurence Hughes	July 2017	H&WB5. Reducing inequality. H&WB 2. Keeping at risk patients independently at home.
Review service and implement actions to reduce the rate of non-attendees (DNAs) to below 5%, thereby making better use of professional resource.	Laurence Hughes	July 2016	H&WB3. Improved patient experience
Continue to review and revise technician's activity to release time to service community equipment, thereby reducing spend on community equipment.	Laurence Hughes	Ongoing	H&WB 9. Resources are used effectively and efficiently.
Development of referral criteria and introduction of self referral in line with the Allied Health Professional National Delivery Plan.	Laurence Hughes in conjunction with Scottish Orthotic Clinical Lead (ScOL) group.	Website being constructed	H&WB 1 and 9
Implement appropriate appointment booking procedure to ensure equity of access to service.	Laurence Hughes	July 2016	H&WB5. Reducing health inequalities.
Ensure access to service operates in line with other services in Scotland by adopting consensus documents under development by ScOL	Laurence Hughes	July 2016	H&WB5. Reducing inequalities. And 9 Effective and efficient services
To continue to seek locum work as income generation.	Laurence Hughes	Ongoing	H&W B 9
To seek new ways of working with localities	Laurence Hughes	pending	H&WB3. Improved patient experience

Key Risks to Delivery

Risk	Mitigation
Loss of key staff in single handed department	Business Continuity Plan in place which is reviewed on a yearly basis
Insufficient budget to respond to demand	Budget is carefully monitored. Access to service criteria under review
Continuity of service whilst move to new building takes place	Suitable plans in place to ensure service continuity

Unable to meet 4 week referral to first contact target due to lack of staff availability (sickness, annual leave etc)	Discussion has taken place with national AHP directors group about achievability of target in very small services.

Performance Targets with links to National Outcomes

Performance target	National Outcome
AHP MSK 4wRTT	NHWO 1, 3
18w RTT	NHWO 3, 9
Reduce DNA rate to 5%	NHWO 9

Contact Details

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Further Reading

- Ambulatory Care Services redesign plan
- Orthotic Dept Business case

3.18 Physiotherapy

Policy context
AHPs as agents of change in health and social care: The National Delivery Plan for the Allied Health Professionals in Scotland, 2012-2015, 18 week wait for others, self-referral, work status, falls prevention.

AHP Musculoskeletal pathway minimum standards: A framework for action 2015-2016
National Health and Wellbeing Outcomes. A Framework for improving the planning and delivery of integrated health and social care services.

Health and Social Care Integration Public Bodies (Joint Working) (Scotland) Act 2014. Core Suite of Integration Indicators.

Proposed National AILP – likely to include falls prevention and vocational rehabilitation
AHP Children and Young People's services are currently undergoing change as a result of the Children and Young Peoples Act (Scotland) 2014 and the introduction of the Children and Young Peoples AHP Plan – Ready to Act, which was launched in January 2016. The new plan aims to equalise services across Scotland with 5 key ambitions focusing on Access, Early intervention and prevention, Partnership and integration, Participation and engagement, and Leadership for quality improvement

Current Services
Physiotherapy helps restore movement and function when someone is affected by injury, illness or disability. At the core is the patient's involvement in their own care, through education, awareness, empowerment and participation in their treatment. The NHS Shetland physiotherapy service covers a wide range of specialties and is based at the Gilbert Bain Hospital, where the majority of patients are seen. Patients are also seen at home, or in care centres, schools and leisure centres if appropriate.

Unscheduled Care:
Physiotherapists work on all wards at the Gilbert Bain Hospital and, with the exception of the rehabilitation ward, the majority of inpatient work is related to unscheduled care. Physiotherapists are available for A&E during the working day to assess/advise as required. There is physiotherapist availability for patients receiving Intermediate Care input who have a physiotherapy need. Our core hours are 0830-1700 Monday to Friday and respiratory on-call cover is provided 0900-1700 at weekends and Public Holidays. The children's physiotherapist also provides an inpatient and A&E service when required. The children's physiotherapy team also plays a key role in palliative care for children along with the children's nurse and will provide input on an unscheduled basis when needed.

Planned Care:
This covers all other aspects of physiotherapy.

Older people:
There is an older people's specialist within the physiotherapy team, however she has a broad caseload which, although predominantly elderly, includes all age groups. There are no elements of the physiotherapy service exclusive to older people and, with the exception of paediatrics, all physiotherapists have a high proportion of older people on their caseloads.

Children's services:
The children's physiotherapy team provides specialist physiotherapy services to children in Shetland. Aims are to identify potential difficulties that may impact on a child's health and wellbeing, maximise the potential of those with long term conditions, encourage and enable children and their families to self manage their conditions and rehabilitate those with short term musculoskeletal problems. A wide range of specialist children's services are provided: neurology,

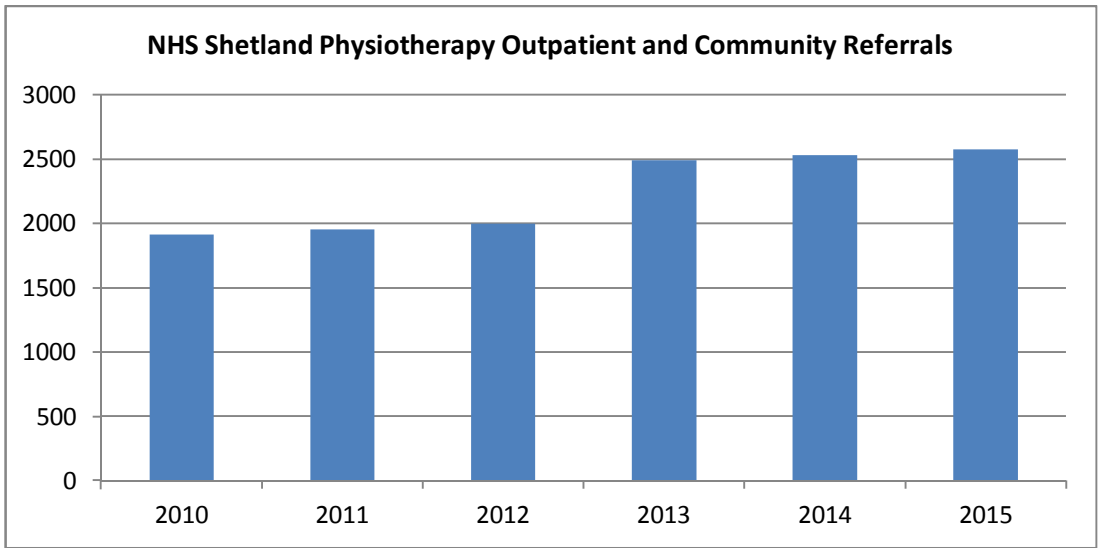
respiratory, orthopaedics, oncology and musculoskeletal physiotherapy as well as developmental and neonatal follow up clinics. Staffing is 1 WTE Band 7 – Highly Specialist Children's physiotherapist – focusing on Early years and complex needs (75% of caseload are pre-school, 25% are school age) and 0.53 WTE Band 6 – Specialist Children's Physiotherapist – focusing on musculoskeletal physiotherapy in school age children (100% of caseload are school age)Workload and caseload are defined by specialty, area or individual practitioner – there is no split between planned and unplanned care or older people.

Funding and Resources

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Physiotherapy	12.89	603,130	0	603,130	0

Needs/Unmet needs/Drivers for change

The physiotherapy service received 2576 referrals in 2015(11 % of the population). Referral rates continue to increase year-on-year. Since 2010 referrals have increased by 35%. The increase in referral is proportional from all sources; i.e. self, GP, secondary care and community and across specialties. This increase in referral rates has been absorbed into existing staffing levels. Additional staffing resources allocated have been for specific service developments, e.g. chronic pain and telehealth.



Self-referral is considered best practice and is a target within the AHP NDP. In 2015 self-referral accounted for 41% of all referrals. Self-referral has, in part, replaced GP referral. In the MSK service where throughput is highest this has given additional challenges – particularly around time taken to triage referrals, seeking additional information and dealing with people presenting with multiple or complex problems.

For children a new form for 'Request for Assistance' has been established in line with the new guidance from the new CYP Plan. This is available for a child of any age needing input.

As a result of high demand with unchanged staffing levels waiting times have increased. Projects are underway in musculoskeletal (MSK) and neurology looking at all aspects of the service, with a view to reducing the workload by referral management and promoting self-management.Increased neonatal follow up – Due to requests to decrease the travel budget and loss of paediatric medical staff, the local neonatal follow up service has been expanded: now all babies requiring a neonatal follow up assessment are seen.

New expectation for increased access (evening and weekend) – The new AHP CYP plan calls for increased access to AHP's including evening and weekend clinics. To date we have provided this on a very limited basis due to the impact on staffing however under the new guidance, there will be an expectation to provide this on a more regular basis. This is unlikely to be achievable or sustainable with a small staffing resource.

GIRFEC – There is a mandatory requirement for involvement in the GIRFEC process and for many of the complex children, physiotherapy have taken the lead professional role. This has resulted in a significant time demand above and beyond the direct therapy contact time for a child.

Due to the small numbers of staff and range of specialties covered it is not possible to cover absence within current resources. Waiting times rise during periods of absence, particularly unplanned or long-term absence. The current financial climate may cause difficulty recruiting to vacancies, which would have a negative impact on appointment availability and waiting times.

The outcomes of the review of acute inpatient rehabilitation and proposals to develop community rehabilitation will impact on physiotherapy services, but the extent of this is currently unquantified.

Plans for change

Description	Lead Officer	Start date/target end date	Expected Outcome(s) (link to National Outcomes)
Review of neurophysiotherapy service	Fiona Smith Margaret Gear	Underway: completion August 2016 May 2016: Partially completed, due to retirement of post-holder and delays in recruiting replacement. Action planning will be completed when replacement is in post.	See PID and Interim report
Review of physiotherapy musculoskeletal outpatients service	Paula Wishart	Underway: ongoing May 2016: Completed April 2016, but further improvement work will be ongoing.	Self management Referral management Reduce waiting times (links to AHP NDP and MSK pathway minimum standards)
Multi-disciplinary Falls Pilot (within current resources)	Elaine Campbell	May 2016: Intervention completed March 2016, but outcome measures and final analysis still to be done (May-June 2016)	Evaluation of results and recommendation regarding future falls programmes (links to AHP NDP)
Active and Independent Living	tbc	tbc	tbc

Programme. To date unquantified and publication awaited. From information currently available this is likely to have a significant impact on physiotherapy services, with new targets set.			
Health and Care Integration and community rehabilitation	Fiona Smith	April 2016	Links to Health and Social Care Integration Public Bodies (Joint Working) (Scotland) Act 2014. Core Suite of Integration Indicators.
Development of Local Implementation Plan	Gemma Passmore	Underway Target end date April 2017	Meet the requirements of Ready to Act – CYP AHP plan

Key Risks to Delivery

- High demand: The risk of rising waiting times if we are not able to keep up demand. This is being addressed through the projects detailed above.
- Complex conditions: Across all specialties we are seeing an increasing number of people with complex conditions. This requires an increased amount of therapist time, clinically and administratively (including liaising with other health professionals or other agencies)
- Children with more complex needs – With new innovations in neonatal care, children who would not have previously survived are surviving but with more complex health needs. This impacts greatly on the service as these children require significant amounts of input in the early years and will require ongoing input as they transition through schools and services. The MOVE programme has been introduced to address the needs of children with mobility issues and physiotherapy provide regular training in this to anyone who wants to be a part of the programme. This has reduced the demand for physiotherapy time in older children enabling the team focus on the younger children - however, the time required for these younger children continues to increase.
- GIRFEC – With the increasing awareness of GIRFEC and the CYP legislation, clinicians input to the GIRFEC process is increasing. In many complex cases, physiotherapy is becoming the lead professional and this requires significant amounts of a clinician's time. An assessment and analysis can take 4-6 hours depending on complexity, a plan 1-2 hours, and a review 2-3 hours not including time for attending meetings. Physiotherapists only take the lead in the most appropriate cases but it has a negative impact on the clinical availability of that staff member.
- Introduction of new national processes – Staff have implemented the new CPIPs programme into their clinical work. In order to reduce the financial implication of this programme, support workers have been trained to assist in the measuring process, however they are not always available for the clinics and a second physiotherapist is needed. The National Selective Dorsal Rhizotomy service is being implemented with specific requirements for physiotherapy: If a child meets requirements for the procedure, there would be a significant impact on the local service which would require an increased staffing resource. This has been highlighted nationally and is also on the local risk register.
- Staffing: Issues with delays in recruitment due to vacancy process and also lack of suitable applicants for posts. Significant difficulty in recruiting to temporary posts.
- Recruitment: current vacancy for highly specialist physiotherapist in neurology. This is the second attempt to recruit. There is a risk that we fail to recruit, or that we appoint a person who doesn't have skills across the full breadth of the poat, wth a resulting need for funding for training.

- Universal Services – The service already participates in the Family Play Day and established the Shetland Family Roadshows which have toured Shetland twice. The new CYP Plan requires all AHP staff to participate in more universal provision however being a small service makes this very difficult to achieve.
-

Performance Targets with links to National Outcomes
AHP NDP
AHP MSK minimum standards

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Further Reading
Chartered Society of Physiotherapy: www.csp.org.uk
Health and Care Professions Council: www.hcpc-uk.co.uk
NHS Inform MSK zone (self-management): www.nhsinform.co.uk/MSK/
AHP National Delivery Plan: http://www.gov.scot/resource/0039/00395491.pdf
AHP MSK pathway minimum standards: http://www.gov.scot/Resource/0047/00476937.pdf
AHP CYP Plan: http://www.gov.scot/Resource/0049/00492486.pdf
Association of Paediatric Chartered Physiotherapist (APCP): http://apcp.csp.org.uk/
CYP (Scotland) Act 2014: http://www.legislation.gov.uk/asp/2014/8/contents/enacted
Shetland GIRFEC: http://www.shetland.gov.uk/children_and_families/GIRFEC.asp

3.19 Podiatry

Policy context
Public Bodies (joint working) (Scotland) Act 2014; National Health and Wellbeing Outcomes; National Delivery Plan for Allied Health Professionals (AHP) in Scotland (2012); NHS Shetland Workforce Plan 2014-17; Localities Planning; 18 weeks Referral To Treatment (RTT); 4 weeks Musculoskeletal (MSK) RTT; AHP MSK Minimum pathway standards; Scottish Intercollegiate Guidelines Network (SIGN); Health + Care Professions Council; Older People Health and Wellbeing Strategy; Scotland's Dementia Strategy 2013-16; Shetland NHS Intermediate Care Operational Plan; Prevention and Management of Falls; Getting It Right For Every Child (GIRFEC); Community Care + Health Scotland Act 2002; Regulation of Care (Scotland) Act 2001; Integration of Health and Social Care.

Current Services
Podiatry Services provide a comprehensive range of treatment, advice and education to the population of Shetland. Services provided include: routine podiatry, nail surgery, nail management, vascular and neurological assessment and screening; MSK assessment and orthoses prescription; footwear advice; falls prevention advice; diabetic foot assessment and screening; wound care. Podiatry aims to provide flexible, creative and responsive actions to allow early intervention and prevention.

Provision of wide range of essential Podiatric services reduces patient journey and prevents duplication of treatment.

Podiatry services have successfully implemented and continue to promote both open and self referral (AHP NDP target), as well as introducing, implementing and enforcing the Personal Footcare guidelines (AHP NDP target).

Funding and Resources

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Podiatry	4.40 (3.6 clinical)	225,020	0	225,020	TBC

Needs/Unmet needs/Drivers for change
Podiatry services will continue to have to provide to frail and elderly. It is clear that the number of elderly in Shetland will increase. This will have demand implications for Podiatry. Existing patients will continue to be provided with scheduled care where assessed and appropriate. The increasing number of elderly patients who are not currently registered with Podiatry will be a potential unmet need and could have unscheduled care requirements.

Government policy and strategy will naturally be important drivers for change.e.g the amended AHP National Delivery Plan.

Podiatry will continue to provide current range of services, but in addition unmet need in falls prevention, vascular assessment, orthopaedic triage, dementia care, wound management, health education and telehealth will need to be addressed.

Increasing awareness, diagnosis and prevalence of mental health conditions has increased reliance upon multiple services. Podiatry inputs to assist patient and/or carer to manage foot health. Keeping patients mobile, out of secondary care and at home.

Children's services continue to develop both as Podiatry only input and as part of greater multi-disciplinary workstreams.

Greater joint working with Physiotherapy has commenced and will continue to develop. Joint working with non-NHS teams, such as falls prevention and care at home will change workload demands. Podiatry has commenced Orthopaedic triage which will continue to increase in frequency. Podiatry team have plans to commence direct referral to Medical Imaging, Orthopaedics, Pain clinics and Rheumatology.

Although a stand alone, voluntary charitable organisation, the Shetland Voluntary Nail Cutting Service (SVNCS) will continue to be supported financially by NHS Shetland. Podiatry Services will continue to provide training, advice and logistical support. The SVNCS has challenges with recruiting volunteers leading to unmet needs of present and prospective service users. Foot care, including simple nail cutting is now classed as a personal care need and is a task for which Social Care now has responsibility. Podiatry Services will maintain its commitment to provide training and advice to social care teams when requested. Podiatry also provides training and support to both paid and unpaid carers to empower them to provide personal foot care to population.

Plans for change

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
Continue to redesign services to ensure service can meet expected demand for podiatric interventions to frail elderly.	Chris Hamer	Ongoing	Maintaining foot health, enabling patients to remain mobile. NHWO's 1,2,3,4,9.
Identify possible opportunities for early intervention in patients with possible signs of dementia. Contributes to savings when early intervention is possible.	Chris Hamer	Ongoing	Recognising and acting upon early signs of dementia assists in diagnosis and treatment. NHWO's 1,2,4,9.
Implement podiatric aspects into falls prevention strategy.	Chris Hamer	Ongoing	Expert and evidenced based interventions for those patients at risk from falls. NHWO's 1,2,3,4,5,7,9.
Contribute to savings targets by triaging orthopaedic referrals.	Chris Hamer	Ongoing	Ensuring referrals are directed to the appropriate clinical service. NHWO's 2,3,4,5,7,9.
Contribute to preventative interventions and savings targets by ensuring vascular intervention and care pathway is implemented.	Chris Hamer	Ongoing	Working across primary and secondary care to produce an effective and efficient vascular care pathway. NHWO's 2,3,4,5,7,8,9.
Introduction of AHP prescribing. Will reduce number of patients requiring appointments with GP/ANP.	Chris Hamer	May 2016 - commenced	Reduce patient journey, free up GP/ANP appointments. NHWO 2,3,5,9.
Incorporating pathway informing patients of availability of medication reviews	Chris Hamer	May 2016- commenced	Reduction in prescribing costs. NHWO3,5,7,9.

Key Risks to Delivery

Risk	Mitigation
Redesign of staffing structure to create efficiencies which may result in a reduction of capacity.	Continual engagement with staff. Monitoring of safe work practices. Flexible leave arrangements.
Staff retention and recruitment. Lack of staff resources to implement and maintain quality initiatives. Need for staff to have both wide ranging generalist and specialist skills. Requirement for defined, fair and equitable recruitment policy.	Engagement with staff. Staff able to input into service changes and improvements. Evidence to be collated to inform Senior management when full range of podiatric interventions is not available within existing resources.
Continued savings	Efficient use of service resources. Use of PECOS and national contracts. Investigation of potential efficiencies.
Clinical facility availability	Efficient use of clinical rooms, sharing use where practicable. Use of alternative clinical facilities.
Complex conditions and co-morbidities Increasing numbers of patients presenting with more complex conditions/co-morbidities will require additional clinical and administrative resources.	Triaging of referrals. Non- urgent cases wait longer than assessed needs. Data to be collated and monitored with regard to waiting times/ unmet needs

Performance Targets with links to National Outcomes

Performance Target	National Outcome
AHP MSK 4wRTT	NHWO 1
18w RTT	NHWO 9
Reduce DNA rate to 5%	NHWO 9

Contact Details

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3.20 Renal

Policy context
To ensure the renal patients receiving renal replacement therapy are meeting the guidelines set by the Renal Association clinical standards.

Current Services
The Renal unit provides renal replacement therapy for the people of Shetland. In addition the service provides pre-dialysis education and monitoring and post transplantation care liaising with Aberdeen Renal Unit and Renal Consultant .The unit provides the opportunity for holiday dialysis whenever possible.

In addition, the renal nursing provide education and support for patients to enable them dialyse at home and provide respite care for these patients as required.

The service cares for patients following peritoneal dialysis and provides home visits if necessary and monitor their adequacy.

Funding and Resources

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Renal	3.50	144,793	0	144,793	TBC

Needs/Unmet needs/Drivers for change
There has been an increase in demand over 2015 and moving forward into 2016, the staff have adjusted working times and days to support the increase in demand for the service. This increase in demand for the longer term will require a staffing review and service provision review.

Plans for change

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
To extend the renal unit by 2 more stations making 6 in all.	Michael Gray	Unknown	unknown

Key Risks to Delivery

- **Water quality**- water testing/ monitoring and result analysis, testing criteria and plan in place.
- **Water failure**- Estates monitoring, adjustment to service provision, and transportation of patients to NHS Grampian for dialysis if required in major water failure.
- **Dialysis machine failure**- 3 new dialysis machines and reverse osmosis machines have been purchased, a spare machine available which will support service continuity. The other two are for the new dialysis stations once the unit has been extended. Servicing of current machines undertaken by NHS Grampian. Major failure would instigate transfer of patients to ARI.
- **Weather related risks** - due to location of patients, if needs be, patients individual dialysis sessions can be changed to accommodate the patients or patients receive their dialysis in Aberdeen.
- **Specialists staffing resource** - staff work flexibly, hours extended where possible to meet services demand .Continued support is required to sustain the renal service and annual training plans are submitted to ensure staff receive the required updates. There are

associated risks with staff sickness / absence and additional resilience is needed within the team to ensure service delivery.

- **Increase in demand for service** - the staff have reviewed their hours and days of work to accommodate the patients and are now full to capacity. This creates an impact on other services in terms of staffing (renal clinics, IV iron etc) which remains a challenge and consideration is required to further expansion of service in terms of staffing. To allow for increased demand for the service it is envisaged the extension to the unit will commence when all plans have been agreed year to allow for additional Shetland patients to receive their dialysis on island.

Performance Targets with links to National Outcomes
There are a number of standards that specifically relate to adult renal service:

- Annual audit is carried out using the Quality Improvement Scotland (QIS)
- Standards for Adult Renal Services.
- Renal Association clinical standards.

Adequacy takes place with the data submissions to NHS Grampian

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Further Reading
Useful links:
Renal web: http://www.renalweb.com/
National Kidney Foundation: www.kidney.org.uk
UK National kidney foundation: www.kidney.org.uk
The Nephron information centre: www.nephron.com
Kidney patient guide: www.kidneypatientguide.org.uk/contents.php
Royal Infirmary of Edinburgh: www.edren.org

3.21 Sexual Health

Policy context
The *National Framework for Sexual Health and Blood Borne Viruses* (2011), reviewed in 2015, builds on previous Scottish Government policy in these areas, including *Respect and Responsibility (2005)* and the *Hepatitis C Action Plan* (2006). It also incorporates the *HIV Action Plan for Scotland (2009)* and work on hepatitis B. A local Sexual Health and Blood Borne Virus Strategy was published in 2015.

Current Services
Strategic planning and co-ordination of services is led by a local multi-agency Sexual Health and Blood Borne Virus Strategy group. It oversees the co-ordination of this area of work in Shetland, including developing the Strategy and workplans and monitoring progress.

There are two main elements to sexual health services: the Sexual health and wellbeing clinic and primary care services. However sexual health work is also incorporated into a number of other services including school nursing and health visiting; secondary care (particularly gynaecology); public health and health improvement; sexual health and relationships education in schools and the voluntary sector (OPEN Peer Education project)

The Sexual Health and Wellbeing (SHWB) Clinic runs once a week in the out-patients department of the Gilbert Bain Hospital and provides both family planning and genitourinary medicine services with health promotion as a key element. It is primarily nurse led with some GP clinics. The service has recently undertaken a project with NHS Grampian to develop telemedicine facilities for patients diagnosed with HIV, including consultant and psychologist appointments supported by the sexual health clinic staff in the hospital outpatient department, reducing the need for patients to travel off island for care and support. During 2015 the service was amalgamated with maternity, early pregnancy, and some gynaecology services to establish a more robust Reproductive Health Service. This new service is managed by the Senior Charge Midwife for Reproductive Health.

Primary Care: There are ten general practices in Shetland. Each offers access to some contraceptive services for their patients and a number also see non-registered patients for contraceptive services. Not all practices currently offer long acting reversible contraception (LARC) but those that do not have arrangements with other practices to ensure the service is provided. All the practices can offer screening for STIs via the local laboratory services and those in Grampian. Emergency contraception is available out of hours: five of the GP practices provide their own out of hours services, the other practices use NHS24. There is also a walk-in primary care service at weekends in the Gilbert Bain Hospital. The five **Community Pharmacies** in Shetland can all provide emergency hormonal contraception free of charge to the patient.

Funding and Resources
It is not currently possible to identify the total costs for Sexual Health Services. There is dedicated income, but this does not cover all the costs. The budget specifically for the Sexual Health and Wellbeing Clinic is outlined below. The funding and resources in other services and organisations that are used to provide sexual health services can not currently be separated out from their overall budget allocations and work force.

The Sexual Health and Wellbeing Clinic has an annual budget of £38,137. Staff are rotated to the clinic from the maternity service and supported by other sessional nurses. In addition, there is a GP and a healthcare support worker at the clinic every other week.

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Sexual Health Clinic	0.56 Sexual Health Clinic	38,145	0	38,145	TBC

	(staffing includes one GP, nurses, HCSWs and admin staff on a sessional basis; managerial support				

Needs/Unmet needs/Drivers for change

- As there is more local and national activity on awareness raising and health promotion, then more people are coming forward to access services
- Demand for the sexual health clinic is increasing; including more people presenting who are at risk but currently asymptomatic; more men attending; and potentially people now coming to the local clinic who previously went to clinics on the mainland (although this is hard to quantify)
- There is also increase demand for long acting reversible contraception as this is being actively promoted: insertion of coils and implants requires specific additional training for staff, which will not be met within current resources.
- It is recognised that access to the Sexual Health and Wellbeing Clinic is limited, especially for people who live out with Lerwick and those that cannot get there in the evening. The development of the reproductive health team should allow greater flexibility in the provision of services out with the clinic.
- There is scope for more work on understanding and addressing the needs of the local LGBT (lesbian, gay, bisexual, transgender) community, and specifically MSM ('men who have sex with men').
- There is scope for more work on understanding and addressing the needs of people locally who may be affected by Gender Based Violence (including rape and sexual assault; childhood sexual abuse; human trafficking & sexual exploitation): this links with the work on Domestic Abuse
- There is scope to improve the pathways for women who require a termination of pregnancy (who currently have to go to Aberdeen) and other services currently provided in Aberdeen utilising telemedicine to provide a satellite service linked to NHS Grampian.

Plans for change

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
Training for nurses / midwives to fit LARC implants	Elaine McCover	December 2015	Reduction in unplanned pregnancy
Training for nurses / midwives to fit contraceptive coils	Elaine McCover	December 2016	Reduction in unplanned pregnancy
Implementation of electronic patient record system (NaSH)	Elaine McCover/Andrew Carlisle	December 2016	ENMAHP health agenda
Look at improving termination pathway to reach 9 weeks target including looking at what elements of the service could be carried out on Shetland	Elaine McCover	December 2016	Reduction in unplanned pregnancy
All pregnant women to have antenatal discussion re contraception, and be discharged from maternity services postnatal with an	Elaine McCover	Complete	Reduction in unplanned pregnancy

effective method of contraception, with an emphasis on LARC			
24/7 provision of emergency contraception through reproductive health service rather than A&E	Elaine McCover	April 2016	Reduction in unplanned pregnancy

Key Risks to Delivery

Training for staff and maintaining competencies

Whilst many courses can be accessed on-line, there is still the need for clinical training and experience which can require time spent 'off island'. The expense of travelling to mainland Scotland and often needing to spend one or more nights away from Shetland can be prohibitive. This is also particularly difficult for nurses in the sexual health clinic who might only work two sessions a month, again this should be improved by the newly established reproductive health team and greater ability to provide some training locally. Where possible, we endeavour to bring trainers to Shetland where this is more cost effective and practical, although sometimes this is not possible because of the relatively small number of people here who require the particular training being offered.

Sustainability of the sexual health clinic

There have been previous attempts at running a clinic in the past, which had been unsustainable largely due to lack of funding, trained staff and managerial support. However, we now have a good structure in place with the clinic integrated into the Reproductive Health Team, and also aim to have sustained clinical leadership through the new consultant post. We also have a team of sessional staff who have undergone training. However, a proportion of funding for the clinic is provided through the prevention Bundle allocation for the Scottish Government , and if this were to stop the service would be under threat.

Performance Targets with links to National Outcomes

National Sexual Health and BBV Outcomes:

Outcome 1: Fewer newly acquired BBVs and STIs; fewer unintended pregnancies.

Outcome 2: A reduction in the health inequalities gap in sexual health and BBVs.

Outcome 3: People affected by blood borne viruses lead longer, healthier lives.

Outcome 4: Sexual relationships are free from coercion and harm.

Outcome 5: A society where the attitudes of individuals, the public, professionals and the media in Scotland towards sexual health and BBVs are positive, non-stigmatising and supportive.

National Key Performance Indicators

Indicator	2013/14	2014/15	2015/16	TARGET 16/17
The proportion of women of reproductive age with intrauterine and implantable contraceptives (LARC):	108.8 per 1000 women	Not yet available		60 per 1000 women
Teenage pregnancy (rate per 1000) for <16 year olds	Not yet available	Not yet available		Maintain at <2 per 1000 (Local target)
Teenage pregnancy (rate per 1000) for <20 year olds	Not yet available	Not yet available		No target

Percentage of termination of pregnancy procedures taking place at less than or equal to 9 weeks gestation per NHS Board.	60.9% (for all 3 island boards)	Not yet available		TARGET 70%
Proportion of women who have had a termination, who leave the facility with one of the more effective methods of contraception (hormonal oral contraceptives, intrauterine devices or contraceptive implants).	Not measured	Not yet available		TARGET 60%

There are currently no national HEAT targets or local SOA indicators relating specifically to sexual health

Contact Details
Reproductive Health Service: Elaine McCover

Further Reading
Healthy Shetland Website: Sexual Health Information, including information and a video and the clinic: www.healthyshetland.com/health-topics/sexual-health

3.22 Speech and Language Therapy

- **Adults**

Policy context
Nationally agreed 9 Health and Wellbeing Outcomes as put in place following the Public Bodies (joint working) (Scotland) Act 2014 and Royal College of Speech and Language Therapy clinical guidelines.

Current Services
Speech and language therapy in Shetland provides life-changing treatment, support and care for adults who have difficulties with communication, or with eating, drinking and swallowing. Speech and language therapists (SLTs) work closely with families, carers and other professionals such as nurses and occupational therapists. SLTs work in the Gilbert Bain Hospital, Care Homes, the SLT base at the Independent Living Centre, people's own homes and at Supported Living and Outreach settings. They work with adults with:

- Communication or eating and swallowing problems following neurological impairments and degenerative conditions, including stroke ,head injury, MS, Parkinson's disease and dementia.
- Head, neck or throat cancer
- Voice problems
- Learning difficulties
- Physical disabilities
- Stammering

Funding and Resources
Please note the income funds the children's service

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Speech & Language Therapy	3.29	180,135	97,000	83,135	TBC

Needs/Unmet needs/Drivers for change
20% of population will have speech, language and communication needs at some time in their life affecting their ability to sustain family and social relationships, income levels, education, employment, health, social care and justice services. Communication and/or eating and drinking difficulties are part of life for many, if not all, people with the following long-term conditions-stroke, head and neck cancers, dementia, autistic spectrum disorder, brain injury, cerebral palsy and motor neurone disease, multiple sclerosis, Parkinson's disease and learning disability
The current Speech and Language Therapy adult caseload is 94 adults, of these, 34 are adults with learning disability. There has been a steady growth in referrals for adults over the past 5 years and this is expected to continue. The current capacity does not allow for development of the service to groups such those with dementia where the service is restricted to providing support to those with dysphagia (swallowing difficulties).

Plans for change
The service is trialling a communication group with the support of the Shetland Stroke Support Group for those with Aphasia (language difficulties following stroke), in order to support those individuals who have moved on from regular therapy and are benefitting from the peer support from the group. The Shetland Dementia Resource Centre Sons and Daughters Group requested some support for those with swallowing difficulties and the SLT department ran a session at their monthly meeting in April 2016. SLT was involved in the multiagency communication skills training programme supporting those involved with Adult Learning Disabilities accessing health care. Further communication training programmes to support those working with and living with people

with barriers to communication will be developed if capacity allows. In the meantime the SLTs will response to individual or group requests for support from carers and families for those with communication difficulties.

Description	Lead Officer	Start date/target end date	Expected Outcome(s) (link to National Outcomes)
Implementation of fast track referral to facilitate discharge	Shona Hughson	November 2015	For Adult LD email/phone named clinician for advice Outcome 5
Implementation of designated phone-in advice and information sessions to ensure more efficient use of qualified Speech and Language therapy resources.	Clare Burke	February 2016	Reduction in travel time for therapists and users Outcome 9 and 5
Implementation of monthly drop -in sessions at Independent Living Centre for patients/ parents with SLT related concern	Clare Burke	August 2016	More efficient use of time and resources, and meeting needs at an earlier stage. Outcome 9 and 5

Key Risks to Delivery

Risk	Mitigation
Reduction in staffing levels, leading to service loss to inpatients with dysphagia and associated life threatening aspiration risk.	Staff retention and maintaining clinical competencies. Dysphagia screening training provided to ward nurses.
High caseload numbers mean limited capacity to provide universal services such as communication skills training to families and carers	Regular monthly monitoring
Removal or reduction of funding from SIC Children's Service to NHS (SIC currently funds 55% of SLT service)	Ensure both NHS and SIC are aware of risks and consequences around withdrawal of funding to service

Performance Targets with links to National Outcomes
HEAT, Single Outcome Agreement or any other performance targets and outcome measures.

Target	Outcome
Patients with swallowing difficulties in GBH – respond within 48 hours	1
6 weeks to first appointment	1

- **Children**

Current Service
Speech and language therapy in Shetland provides life-changing treatment, support and care for children who have difficulties with communication, or with eating, drinking and swallowing. Speech and language therapists (SLTs) work closely with parents and other professionals such as teachers, psychologists and other AHPs. SLTs work in schools, early years settings, the SLT base at ILC and in peoples own homes. They work with babies with feeding and swallowing difficulties and children with:

- Mild, moderate or severe learning difficulties
- Physical disabilities
- Language delay
- Specific language impairment
- Hearing impairment
- Specific difficulties in producing sounds
- Cleft palate
- Stammering
- Autism/social interaction difficulties
- Voice disorders
- Selective mutism

Needs/Unmet needs/Drivers for Change
The current SLT children's caseload is 267 children, 2 FTE SLTs funded through the SIC children's service. Service demand exceeds capacity. Nationally a move towards greater SLT involvement in universal rather than targeted input is expected and a move away from what is considered more "traditional "therapy models advocated.

Plans for change
Locally the service is considering alternative therapy options including:

- phone in advice and information sessions
- monthly drop-ins,
- parent groups,
- as well as ongoing trials of "5 minute therapy",
- outcome measures
- joint group work with early years providers.
- looking into involvement into a research project on use of VC/Skype and SLT provision

Key Risks to Delivery
The key risks to delivery involve any reduction in staffing levels as demand already exceeds capacity. Staff retention and maintenance of clinical competencies are essential in order to at least maintain current levels of service delivery. Monthly caseload monitoring is in place. Work life balance treated with consideration and links established and maintained with local SLT students and graduates. We have struggled in the past to fill vacancies both temporary and permanent.

Performance targets
Waiting times for new referrals, SLTs aim to offer a first appointment within 6 weeks and this is usually achieved. Open referral policy is in operation and self referral is available.

Contact details

Speech and Language Therapy Department
The Independent Living Centre
Gremista
Lerwick
Shetland
ZE1 0XY

Telephone: 01595 744242
Email: shet-hb.SpeechDepartment@nhs.net

Royal College of Speech & Language Therapists: www.rcslt.org (for policy position papers on e.g. dementia, learning disabilities.)

3.23 Unscheduled Care

Policy Context
Unscheduled care is an umbrella term used to describe services which provide an emergency or unplanned service response. The majority of unscheduled care takes place in the community setting and is managed by community health and social care teams.

The overarching aim of services aligned to unscheduled care activities is to provide safe, effective and person centred care for patients who are presenting to health or social care services 'in an emergency'. Unscheduled care takes place across community, hospital and specialist settings.

The national policy context is very broad and includes: the Public Bodies (Joint Working) (Scotland) Act (2014); 20:20 Vision (2011) and the Patients Rights Act (2011).

Other policy areas include the review of service sustainability particularly the reform necessary to support sustainable workforce and safe, seven day service provision. The importance of planned care services is described in local strategies and plans e.g. the older people's strategy (2015), dementia strategy (2015), mental health strategy (2013), integration fund plan (2015-16, refreshed annually), corporate action plan (2015-16, refreshed annually), unscheduled care plan (2015-16) and winter plan (2015-16, refreshed annually).

Our high level aims to support the delivery of unscheduled care services, which are also aligned to the unscheduled care collaborative essential actions include ensuring that we deliver:

- Clinically Focussed and Empowered Hospital Management
- **Hospital Capacity and Patient Flow (Emergency and Elective) Realignment**
- **Patient Rather Than Bed Management – Operational Performance Management of Patient Flow**
- **Medical and Surgical Processes Arranged to Improve Patient Flow through the Unscheduled Care Pathway**
- **Seven Day Services Appropriately Targeted to Reduce Variation in Weekend and Out of Hours Working**
- **Ensuring Patients are Optimally Cared for in their Own Homes or Homely Setting**

Current Services Provided

The majority of healthcare services have an unscheduled care pathway, but the main ones can be defined[6] as:

- **Out of Hospital Services – e.g. community nursing and primary care services 'out of hours'**
- **Accident and Emergency Services**
- **Acute Inpatient Medical Services (including admission of renal patients)**
- Acute Inpatient Surgical Services
- Critical Care Services
- Theatre Services
- Obstetric Services
- Emergency Service provision at NHS Grampian for patients requiring specialist interventions
- Diagnostic Services (e.g. Medical Imaging, Laboratory Services)

In addition to this, NHS partners such as NHS24 and the Scottish Ambulance Service (SAS) play a critical role in the co-ordination of unscheduled care, including the provision of air transfer and

[6] The services shown in bold are part of the joint service planning arrangements set out in the Integration Scheme – known as part B 'set aside' services.

critical care retrieval for adults, children accessing tertiary care centres and patients accessing specialist mental health facilities.

The services which are shown in bold are part of the integrated commissioning arrangements. Separate plans have been produced which set out diagnostic service provision (e.g. Medical Imaging and Laboratory Services) as they operate across acute and community services and support specialist, planned and unscheduled care delivery. Child and Family Health Services and specialist off island services are also shown in separate plans.

Funding & Resources
Jointly Commissioned Services

Service	Number of Staff (FTE)[7]	Expenditure	Income	Net Budget	Savings target[8]
Unscheduled Care	58.19	3,190,371	0	3,190,371	420,000

Drivers for Change
Over recent years, services that provide unscheduled care have been under increasing pressure. There are a number of factors which have caused these pressures:

- A growing elderly population with increasing and complex health and social care needs
- Increasing public expectation of and access to health and social care services
- Delays in accessing up-to-date patient information - impacting on or slowing down clinical decision making
- Need for improved team working and better co-ordination of care between NHS partners (primary care, SAS, NHS 24, secondary care and tertiary care)
- Need for greater collaborative working to reduce delays particularly at the health and social care interface
- Need for closer working between health and social care services to develop integrated models of anticipatory and community based care
- Challenges in training, recruitment and retaining of staff

Another important factor impacting on unscheduled care delivery and is a key driver for change is the relationship between planned and emergency care services. Wherever possible, planned and emergency care should be streamed separately to reduce the impact of cancellations when emergency care services in particular, are under pressure. This can be very challenging to achieve, because our clinicians are generalists and so support both elective and emergency care pathways. Our winter planning arrangements as well as a local focus on the strategic development of primary care services and medical staffing models help to support the sustainable delivery of unscheduled care and planned care services.

National and local priorities are aligned to meeting these challenges through a focus on:

- Health improvement and self management strategies
- Promoting personal and community level resilience and accountability for health and wellbeing
- Developing an integrated approach for older peoples services delivery across health and social care
- Developing robust models for dementia care and community mental health services
- Effective health and care pathway design across primary, secondary and specialist care

[7] Establishment is taken from 2015/16 workforce plans

[8] Applied as 3% savings to each budget area – most savings will be made against schemes rather than top slicing from individual budget areas

- Effective models of planned care delivery e.g. Delivering Outpatient Integration Together (DO IT)
- Strategic plans to support Living and Dying Well

Plans for Change
The indicative savings target for unscheduled services in 2016-17 is £221,521. This is equivalent in staffing costs to a reduction of FTE 7 Band 5 (midpoint) in the establishment across the budgets identified. The focus is not on top slicing staffing costs to make savings but rather the identification of ways in which we can:

- Deliver care closer to home through locality based teams and services (reducing reliance on hospital and care home resources)
- Invest in patient education, self care and self management
- Use technology more to support people at home e.g. telecare, tele-health
- Working collaboratively with the third sector to provide services which help people to access services/support in the community
- Streamlining pathways – reducing the reliance on outpatient services and delivering more complex assessments with practitioners in the community
- Reduce inefficiency and short term spending on locum/supplementary staffing by changing the skill mix in teams

Our strategic priorities for planned care as set out in the Corporate Action Plan (2015-16 and beyond) and the various strategies referenced above can be summarised as follows:

- Managing patient flow - recognising the increase in admissions and demographic changes meaning patients with more complex needs are presenting through emergency care services and discharge planning models need to be revised
- Implementing a joint strategic approach to the delivery of older peoples care across health and social care sectors – particularly our objective to develop a locality based approach to provide more community assessment and support options
- Focus on ensuring that we can provide appropriate care settings/resources/pathways (jointly) to ensure that clinical and care needs are met in the community, whenever it is safe to do so
- Reducing the number of people who are delayed in hospital
- Reviewing the current provision of Out of Hours (OOHs) services to ensure they are sustainable
- Developing ambulatory care and day care models as a safe alternative to inpatient care
- Role development to support unscheduled care service delivery – particularly the positioning of advanced NMAHP practitioners in Acute and Community based care settings

Description	Lead Officer	Start date/target	Expected Outcome(s)	National Outcomes
Review NMAHP skill mix to support sustainable workforce (incorporating the medical staffing review)	Director of Nursing & Acute Services (DNAS)/ Director of Community Health & Social Care	Scoping exercise 2015-16 Options selection and implementation 2016-17 onwards	Increased role development for NMAHPs with advanced practice skills Increased number of NMAHPs supporting unscheduled/primary care e.g. OOHs Increased anticipatory care plan development/access Increased access to care to OOHs care packages Reduced locum costs (e.g. for GP vacancies)	Resources are used effectively and efficiently H&SC services are centred on helping to maintain or improve quality of life People using services are safe from harm
Reviewing out of hours service	Ralph Roberts	Scoping exercise		Resources are used effectively

Description	Lead Officer	Start date/target	Expected Outcome(s)	National Outcomes
provision (including medical staffing, primary care configuration and locality based services)	(Chief Executive)	2015-16 Options selection and implementation 2016-17 onwards		and efficiently
Reviewing the management structure for Acute & Specialist Services	Director of Nursing & Acute Services (DNAS)	Ongoing from 2015	Improvement management capacity to support service delivery Improved skill mix (ratio of professional management to clinical management roles) Reduced management costs	Resources are used effectively and efficiently
Reviewing the management structure for Community Care services		Scoping exercise 2015-16 Options selection and implementation 2016-17 onwards	Improvement management capacity to support service delivery at a locality level Improved skill mix (ratio of professional management to clinical management roles) Reduced management costs	Resources are used effectively and efficiently

Key Risks to Delivery
Key issues (as set out in various local strategies/corporate action plan etc) include:

- Unscheduled care is a complex series of inter-related services and pathways – it is critical that service redesign forms part of a 'whole system' strategic exercise with all partners working to shared objectives
- Pace of change – developing robust community based models will take time and resources. We need to ensure that acute service delivery can be safely sustained whilst service redesigns are completed and new models developed and implemented
- Increase in demand for acute services due to demographic changes and case complexity

Targets/Outcomes
There are a number of HEAT targets that specifically relate to quality or performance markers for effective emergency care systems and they are summarised below with a snapshot of the Performance Dashboard (October 2015).

Ref	Target Description	Freq	Period last	Perf	Period current	Perf	RAG	Vs last	Traj	Target Date	End Target
E.4.2S	Total Delayed Discharges (count)	M	2015 Aug	2	2015 Jul	2	**R**	→	0	2016-03	0
E.9	No people will wait more than 14 days to be discharged from hospital into a more appropriate care setting, once treatment is complete, excluding complex needs codes (count)	M	2015 Aug	0	2015 Jul	0	**G**	→	0	2016-03	0
A.7S	A&E 4 Hour waits	M	2015	94.1	2015	96.2	**A**	↓	98	2016-	98

89

	(percentage)		Aug		Jul					03	
A.8.1S	48 hour Access - GP Practice Team (percentage)	A	2014	93.5	2013	89	**G**	↑	90	2016-03	90
A.8.2S	Advance booking - GP Practice Team (percentage)	A	2014	73.2	2013	73	**R**	↑	90	2016-03	90
BSC17	Level of Older People with Complex Care Needs Receiving Care at Home (percentage)	Q	2015 Apr-Jun	48	2015 Jan-Mar	40	**G**	↑	39	2016-03	39
T.10	Rate of attendance at A&E (rate)	M	2015 Aug	3094	2015 Jul	3021	**A**	↓	3061	2015-12	3061

Contact Details
Kathleen Carolan, Director of Nursing & Acute Services, kcarolan@nhs.net

Further Reading
Older Peoples Strategy, Corporate Action Plan, Unscheduled Care Strategic Plan:
http://www.isdscotland.org/Health-Topics/Emergency-Care/

4. NHS Support Services Plans

4.1 Estates and Facilities

Policy context
The Estate & Facilities service is designed to support the overall vision of NHS Shetland. It therefore aspires to provide and maintain ***sustainable, high quality properties and facilities services*** that allow the effective delivery and continuous improvement of healthcare across Shetland.

Current Services
A detailed summary of the physical assets supported by the Estates department are included in the PAMS (see link). These include the Gilbert Bain Hospital, the Montfield site including Dental services, Staff development and Board HQ and 10 Health centres and 4 clinics spread across the Shetland mainland and outer isles. There are also a number of other small owned properties (i.e. St Olaf Dental practice) and privately owned premises from which NHS contractor services are provided (i.e. Pharmacies and Opticians).

All the NHS Shetland owned buildings, Health centres and Medical equipment assets are supported by an Estates function that carries out planned and reactive maintenance, capital planning, minor repairs and schemes and a Medical Physics function.

The facilities services provided by the Directorate include Domestics, Catering, Porters and Laundry and Linen services.

The service is obliged to maintain compliance with a range of indicators. A number of these are national KPIs and others link to legislative requirements (e.g. Legionella, Hospital Gases, Building regulations, Fire safety, etc, etc.)

Funding and Resources
The total budgets and workforce for the department are:

Estates:	Revenue - £ 1.99M, Capital - £1.1M;	Staffing – 15.5 FTE
Facilities:	Revenue - £1.66M	Staffing – 71.12 FTE

The savings target for 2014/15 was £202k

The savings target for 2015/16 is a further target of £122k and outline plans have been identified to achieve this.

The savings target for 2016/17 is a further target of £177k and outline plans have been submitted to achieve this.

Future year on year targets are anticipated to be 3%

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Estates & Facilities	82.08	3,726,073	0	3,726,073	TBC

Needs/Unmet needs/Drivers for change
The savings target for 2014/15 was £202k

The savings target for 2015/16 is a further target of £122k and outline plans have been identified to achieve this.

The savings target for 2016/17 is a further target of £177k and outline plans have been submitted to achieve this.

Future year on year targets are anticipated to be 3%

Plans for change

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
Property and Asset Management Strategy 2015 (PAMS) sets out the list of priorities over next year, five years and 10 years	Lawson Bisset	2015	Refer to PAMS

Key Risks to Delivery
The key risks, as identified above are the availability of adequate resources to support the services required. This includes both staffing, linked to recruitment and retention and finances (revenue and capital budget). Along with other support services the E&F directorate is currently working to deliver a 25% efficiency target over a 5 year period.

Agreement has already been reached to provide recruitment & retention "premia", linked to Agenda for Change T&C's for key trades staff and this has been agreed for a period of 3 years until March 2017.

In addition work a joint project is also underway to maximise opportunities from joint working with Shetland Island Council.

Performance Targets with links to National Outcomes
The PAMS sets out a range of KPIs and mechanisms for performance monitoring. This includes indicators on:

- Energy Efficiency (HEAT)
- Property : SCART (quality indicators); Backlog maintenance etc
- Facilities: Patient Satisfaction (IP survey); Cleanliness Audits;
- Within the SAFR all Estates & Facilities services across Scotland are also measured for efficiency and comparative cost

Contact Details
Lawson Bisset
Head of Estates and Facilities
Email: lawson.bisset@nhs.net
Tel: 01595 743029

4.2 Finance

Policy context
The organisation has a statutory duty to break even and the directorate role is to ensure efficient stewardship of resources and delivery of the government best value programme for public funds.

Current Services
The Finance Directorate includes the Board Finance Department, the Finance Department, the Patient Travel Department and the Central Stores Department.

Board Finance – This department represents the Board's Director of Finance and central corporate expenditure such as insurance costs, legal expenses and audit fees.

Finance Department – Responsible for the financial stewardship of the Board and has a statutory obligation to produce annual accounts and associated reports. The department provides timely, accurate financial information to heads of departments to aid them in their organisational decision making. Through service level agreements with NHS Grampian provides the Board's Payroll Service and Accounts Payable/Receivable functions.

Patient Travel – Responsible for the booking of all patient travel to and from various mainland health Boards particularly NHS Grampian. The department manages the Highlands & Islands Travel Scheme (HITS) and all relevant reimbursements to patients.

Central Stores Department – Responsible for the five rights of procurement to ensure goods/equipment/services are available of the right quality, in the right quantity, in the right place, at the right time, at the right price. Being an Island Board the department must ensure there are adequate stock levels across the Board to deal with adverse weather conditions frequently experienced in Shetland. A service level agreement is now in place with National Services Scotland to provide strategic procurement and systems management for the Board.

Funding and Resources
Table of budget and savings targets, including workforce details

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Finance	13.30	1,899,352	0	1,899,352	TBC

Needs/Unmet needs/Drivers for change
Drivers for change include reducing budgets combined with a greater appetite for financial information in the current climate. With demand increasing on the department it will be very difficult to maintain the level of service whilst continuing to find additional savings year on year. There is also a shared services initiative under way where Finance/Stores may be merged with other Boards or nationally into central hubs.

Plans for change
With demand for financial information increasing the Finance Department has recruited a band 4 Finance Officer to assist with the monthly closedown process. This will allow us to achieve an 8 working day closedown which corresponds to best practice in the NHS. This has released more accountant time to support redesign projects and efficiency schemes.

Service levels in Shetland have now been reduced to a minimum with Payroll, Accounts Payable & Receivable and Strategic Procurement outsourced to NHS Grampian and National Services Scotland through a Service Level Agreement.

As a result of outsourcing these services, the Finance Directorate has achieved all of its savings target up to and including the financial year 2016/17.

Key Risks to Delivery
Budget constraints may result in a lower level of service and there is ongoing difficulty in recruiting and retaining staff.

Performance Targets with links to National Outcomes
No performance targets as such but regular scrutiny by External & Internal Audit which results in continuous improvement of the service.

Contact Details
NHS Switchboard 01595 74 3000

4.3 Human Resources and Support Services

Policy context
Service changes are currently being driven by the introduction of a National IT platform EESS. NHS Shetland commenced implementing the system in 2012 at Phase 2 of the national programme. There have been numerous setbacks and delays involving developments to the system. Successful implementation will support the progression of the national HR Shared Service (HRSS) agenda that will centralise some HR services.

Current Services
The department provide the following services:

- Job Evaluation
- Recruitment planning and advertising
- Coordination of recruitment interviews
- On Boarding Administration for new starts
- Pre-employment checks
- Relocation monitoring
- Exit interviews
- Professional Registration monitoring
- Issue of ID badges
- Absence monitoring / promoting attendance
- Employment law / employee relations /case management advise, conduct , capability, grievances, whistle blowing, bullying and harassment
- From informal to formal investigation / hearing / appeal / tribunal
- TUPE guidance and due diligence administration
- Consultation on change
- Workforce data monitoring / returns (vacancy, FTE/ turnover/FOI's/ Junior Doctor)
- Workforce planning – projections and reports
- Redeployment
- Policy and procedure development
- Training delivery
- Equality and Diversity – policy, monitoring, action plans

Policy and procedures can be found on the department intranet page http://intranet/departments/hr/index.html and website http://www.shb.scot.nhs.uk/board/policies.asp

Funding and Resources

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Human Resources	10.70	522,353	0	522,353	TBC

A change in skill mix will provide a 3K recurring saving. Non pay savings continue to be found by modifying how services are delivered and the flexibility of the team.

Needs/Unmet needs/Drivers for change
Following the implementation of EESS in 2013, we released 1 FTE Band 3 vacancy to savings. The reduction was planned following successful implementation; however full implementation of the system is not yet complete. National delays in advancing the implementation of EESS and the lack of clarity regarding the impact of HRSS locally has resulted in a holding position, lengthening implementation plans and depending on flexibility form within the team to meet workload demands. HRSS will continue to shape skills requirements within the team.

Plans for change

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
National HR Shared Services for Recruitment and Medical staffing	HRSM	Likely to proceed in the next 2-5 years	Outcomes still to identified, redeployment of HR staff as applicable

Key Risks to Delivery
HRSS is nationally driven programme that will aim to centralise administration of recruitment and medical staffing within the next 2-5 years. There will be some discretion to determine what staff are required locally to support local service delivery. Staff and Manager's will require training for the EESS system to enable them to self administer recruitment administration activities within the system, including vacancy and candidate administration / coordination of short listing, interview and on boarding which is currently carried out by HR. Costs may shift from HR if the demand for administration support across other services increases and local pay costs may increase overall rather than decrease and local expertise will reduce.

Performance Targets with Links to National Outcomes
Reduction in administration demands will enable HR resource to refocus responsibilities on supporting resource planning, redesign, integration of services, effective performance management and management of change, policy development and training delivery. This will include monitoring and reporting of absence / attendance against the 4% HEAT target.

Contact Details
Lorraine Allinson, HR Services Manager 01595 743071, lorraine.allinson@nhs.net.

Further Reading
HRSS project Initiation document:
http://www.qihub.scot.nhs.uk/media/611088/hrss%20-%20pid%20-%20may%202014.pdf

Quality Improvement Hub:
http://www.qihub.scot.nhs.uk/quality-and-efficiency/shared-services.aspx

4.4 Information Management & Technology and eHealth

Policy context
Service changes are currently being driven by the introduction of a National IT platform EESS. NHS Shetland commenced implementing the system in 2012 at Phase 2 of the National programme. There have been numerous setbacks and delays, involving developments to the system in order for it to be fit for purpose. Successful implementation will support the National HR Shared Service (HRSS) Agenda.

Current Services
The department provide the following services:

- Installation, management and support of IT infrastructure including servers, storage and network services.
- Management of Clinical, and Business application systems
- Installation, management and support of telephony including landlines, mobile phones, and pagers
- Multifunction devices (scanner/copier/printers)
- System integration services
- Freedom of Information administration
- Information Security
- Information Governance
- Information services and healthcare intelligence
- National eHealth leadership
- North of Scotland regional eHealth leadership and programme delivery
- Policy and procedure development
- Training delivery

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Information Technology	15.00	1,100,100	0	1,100,100	TBC

We do not anticipate savings in pay budgets in 16/17 due to pressure on existing resources to deliver service however dependent upon the level of savings and percentages required this may change post Feb 2016 and if so is likely to be in the region of 5%. Recurrent savings of £30,000 anticipated in non-pay IM&T budgets by reducing hardware refresh rate, and reduction in telephony maintenance charges.

Needs/Unmet needs/Drivers for change
The use of technology in NHS Shetland is increasing, and the number of systems supported continues to increase. The department has recently taken responsibility for training staff on a number of clinical systems and provides administration of those systems. On this basis, it has been identified that an increase of 2FTE Band 5 is required to deliver service.

All public sector organisations will be required to comply with the Public Records Act in 2016/17. This will involve significant change in the management of information assets across all areas. On this basis 1 FTE Band 6/7 will be required to meet the requirements of the Public Records Act, and provide ongoing stewardship of information assets thereafter. It is anticipated that such a resource would organisationally fit within this department.

Plans for change

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
Increased use of technology to reduce patient and staff travel	Head of IM&T/eHealth	Commenced December 2015. Ongoing programme expected to run for 12 months.	Reduction in travel expenditure across the organisation. Improved patient care due to reduction in travel
Implementation of Records Management Plan to support compliance with Public Records Act	Director of Finance	Commencing April 2016.	Compliance with Public Records Act (mandatory).
Implementation of on-line services for patients	Head of IM&T/eHealth	Programme commencing April 2016, subject to national funding	Reduced DNA rates, reduced patient appointments Improved patient care through increased self-management of care

Key Risks to Delivery
Cost pressures – savings targets for core budgets, and reduction in Scottish Government eHealth allocations.

Insufficient staff – change programmes that will deliver recurrent savings are challenging to implement as staff are fully utilised supporting and maintaining existing systems.

Skills gaps – records management (Public Records Act) is a fundamental change to management of information assets, and suitable skills are challenging to recruit in remote areas.

Performance Targets with links to National Outcomes
The national eHealth Strategy, which supports the national Quality Strategy, includes outcome measures that we report to Scottish Government quarterly.

Contact Details
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Further Reading
Scottish Government / NHS Scotland eHealth Strategy 2014-18:
http://www.gov.scot/Resource/0047/00472754.pdf

4.5 Medical Records

Policy context

Current Services
The Medical Records Department provides various functions within NHS Shetland.

Our purpose is to provided, secretarial cover for local and visiting consultants, ward clerks, patient focus booking with outpatient receptionist, clinical coding, and main hospital reception cover. We do this by booking patient appointments, inpatient and outpatient in a timely fashion in accordance with the rules set down by the Scottish Government, ensuring that clinic letters, discharge letters are processed in a timely fashion. Procedures are coded correctly and within the time scales provided so that statistics can be provided on a monthly basis to the Scottish Government on the performance of NHS Shetland.

The main hospital reception is the centre for greeting the general public coming into to the Gilbert Bain, it also the main point for internal and external mail, Telephone exchange for the Gilbert Bain. It also acts as the first point of contact for emergency services in the hospital.

Funding and Resources

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Medical Records	27.99	896,660	0	896,660	TBC

Needs/Unmet needs/Drivers for change

Plans for change

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
Succession Planning for Health Records Manager	Kathleen Carolan	October 2015	N/A

Key Risks to Delivery
Health Records Manager, retiring at end of 2015, succession planning currently being discussed with staff.

The Reception supervisor will be going off long term sick, cover is in place but this could be fragile and lead to additional spend on the budget.

Performance Targets with links to National Outcomes
N/A

Contact Details
Health Records Manager 01595 743033
Health Records Supervisor 01595 743015
Clinical Coder & PFB Team Leader 01595 743223
Reception Supervisor 01595 743000

4.6 Occupational Health

Policy context
Service changes are currently being driven by external and NHS local demand for services and nationally with national performance target for sickness absence of 4% and the introduction of the Fit for Work Service Scotland and also requirement for accreditation via SEQOHS.

Current Services
The department provides a range of services including:

- Management referrals for absence / performance case management
- Self Referral -NHS Staff
- CBT relating to personal or workplace issues / change
- Health Surveillance
- Immunisations
- Pre-employment screening
- Health Checks
- Work related Vaccinations
- Workplace/ workstation assessments
- Night Worker assessments
- Needle stick Injury response
- Stress management
- Medicals
- Ill Health Retirement
- Staff Training

Details can be found on the staff intranet http://intranet/departments/oh/index.html

In addition to a local OH service the department are set up to support the delivery of the Fit for Work Service Scotland as this is rolled out.

Funding and Resources

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Occupational Health	3.00	167,332	55,630	111,702	TBC

Pay budget includes visiting consultant from NHS Highland. 4K recurring saving has been agreed from pay budget for 2016/17, which is only in current state of service demand. Line management and business management of SLA with NHS Highland is via the HRSM for which costs are included in Personnel plan & not included in above. There is a cost pressure for system development and achievement of the SEQOHS accreditation to maintain current service for which additional income has continued to cover in the last 2 years.

Key Drivers for change

- Legislation: Equality Act provides an increasing need for assessment and supportive adjustments in the workplace
- Demographics - Ageing workforce - complex health needs
- Increase in stress & MSK related absence
- Need to work more efficiently within reduced budgets
- Local business demand for services has increased. This has enabled our consultant to become an approved Doctor for the MCA, so we can offer ENG1 medicals to our customers
- Requirement for SEQOHS professional accreditation for which the department are working towards

- National Fit For Work Service implementation programme – local participation in national implementation plan

Plans for change
The introduction of the FFWS in Scotland, funded through the Department of Working Pensions (DWP) may reshape external customer service demands as this service will focus on referral from the GP / employer into a national service, for those with 4 or more week's sickness absence from work. NHS Shetland will participate in service delivery with allocation of referrals via a central call centre (NHS 24). The service level will be managed separately via a defined SLA. Telephone equipment and system are in place. Additional resource will be required to be trained to deliver this contract, for which funding allocation is to be agreed.

Current SLA with SIC will cease 31 March 2016. NHS Shetland has submitted a tender for a revised contract for services commencing 1 April 2016.

Description	Lead Officer	Start	Expected Outcome(s) (link to National Outcomes)
Introduction of Fit for Work Service	SOHN	2015/16	National reduction in sickness absence from work
OH Tender for SIC	HRSM/ SOHN	2016/17	To be confirmed in January

Key Risks to Delivery
- The FFWS set up costs to be recovered from DWP January 2016 – awaiting confirmation of ongoing funding / service demand. Service Level Agreement is in place for FFWS for 0.5 FTE Band 6. Current staff have supported 'set up' in readiness for commencement of the service. Local start delayed, awaiting training from NHS Lanarkshire, the FFWS lead for Scotland.
- There is a risk that we may lose income if Shetland Island Council do not accept the occupational health tender submission. Failure to generate sufficient income to replace this would require a reduction in staff required to deliver remaining demands.
- The department are set up to participate in the delivery of the Fit for Work Service Scotland. Reimbursement from DWP is outstanding for set up arrangements / training costs. No funding has been received yet and unlikely until January 2016. Resource to deliver will be dependent on availability and level of funding provided.
- Retention of skilled staff will be essential to maintain service delivery levels – local availability of appropriate skills is very limited therefore national recruitment or use of a specialist agency would be required to fill any turnover or any increase in resource requirements.

Performance Targets with links to National Outcomes
In the event there was a reduction in income and demand, service would continue to provide support for NHS staff in maintaining health, wellbeing and fitness for work. The service supports the achievement of the 4% performance HEAT target for absence and reduces risk in relation to the Equality Act 2010, providing guidance on adjustments. Without a local service we would unlikely maintain current performance which is consistently below the Scottish average or achieve the 4% absence target.

Contact Details
Lorraine Allinson, HR Services Manager
Telephone: 01595 743071,
Email: Lorraine.allinson@nhs.net.

Further Reading

- FFW: http://www.fitforworkscotland.scot/
- Equality Act: http://www.legislation.gov.uk/ukpga/2010/15/contents
- NICE Guidelines https://www.nice.org.uk/guidance/ng13
- Procurement Highland local authority:
- http://www.google.co.uk/url?url=http://www.highland.gov.uk/download/meetings/id/40290/item20res7710pdf&rct=j&frm=1&q=&esrc=s&sa=U&ved=0CBQQFjAAahUKEwi9qeTamMLIAhXCPxQKHTxaAIw&usg=AFQjCNHoPUDGtqKdggY1JgymN0NA7RSdOw
- Previous OH tender: http://www.publictenders.net/tender/349150

4.7 Spiritual Care

Policy context
The current NHS Shetland Spiritual Care Policy dated Sept 2006 was to be reviewed Sept 2008. The policy will be updated in 2016 reflecting the NHS HDL (2015) National Delivery Plan for Spiritual Care 2015 – 2020, due to be published in 2016. Boards and Spiritual Care departments have worked hard to implement the recommendations made in CEL (2008) 49. The revised guidance (Annex A) and the new national delivery plan (Part Two) aim to further develop the Spiritual Care Service in the light of the integration of Health and Social Care. The 2020 vision, the integration agenda for health and social care and person centred care.

Current Services
There is a full time Spiritual Care Lead chaplain in a joint/shared post with NHS Orkney who oversees a multi faith spiritual care service. The spiritual care lead's main remit is staff support and to develop and ensure the delivery of spiritual and religious care across NHS Shetland. The Spiritual & Religious Care Service provides spiritual and religious care to NHS Shetland across primary and acute healthcare and social care in the local community. The intention would be to further expand the service over the next 5 years to create a well-integrated service that will meet the spiritual and religious care service for staff, patients, family, carers and the community.

Due to the geographical factors of NHS Shetland, and to ensure equity of spiritual care provision across Shetland, 6 volunteers have been recruited and trained by the spiritual care lead who will provide spiritual care on the wards in the Gilbert Bain hospital, for patients, families and carers supervised by the spiritual care lead. There will eventually be volunteers recruited and specialist trained to provide a listening service, attached to GP surgeries, under the umbrella of CCL – Community Chaplaincy Listening, this is a GP referral service to benefit all patients which includes carers and family members. Staff support is provided on an ad hoc basis by referral, for e.g. from HR and Occupational Health, self referral and via managers, team leaders and working relationships with departments and professional teams. This includes following the asset-based approach of networking within the community.

A tool that enables staff wellbeing is VBRP – values based reflective practice, facilitated by the spiritual care lead in regular sessions across health and social care and are is introduced through staff education and development. VBRP is also included as a useful tool within the nursing revalidation. The bereavement support lead role involves the spiritual care lead attending occasional quarterly meetings in person and via Video Conferencing at National Education NHS Scotland, Glasgow to remain up-to-date with current and national bereavement support policies and guidelines which will benefit staff, patients, families and carers.

Funding and Resources
The options appraisal and service review will make recommendations which will potentially have an impact on recommended future staffing levels.

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Spiritual Care	0.50	64,924	24,246	40,678	5%

Needs/Unmet needs/Drivers for change
Spiritual & Religious Care assessment to be undertaken in 2016 with the update of the Spiritual Care Policy. A service priority will undertake a needs analysis in terms of service delivery and it is anticipated that the review will examine access to the service and ongoing provision of support to staff, patients, families and carers. A needs analysis will recommend future staffing levels for a service which is appropriately responsive to the needs of staff, patients, families, carers and users and in accordance with key government drivers and the CEL.

Plans for change
Service redesign has been the main purpose of the spiritual care lead's remit throughout 2015. Guided by the CEL update, VBRP for staff support, ensuring evidence and outcomes meet national guidelines. Quarterly attendance at SLG meetings, NHS Education for Scotland and annual professional SLG conference. More volunteers will need to be recruited to fulfil equity of spiritual and religious care across primary care. The spiritual care lead in 2016 has also taken on the role of Bereavement Support Lead for NHS Orkney and NHS Shetland. Working with colleagues across health and social care in Shetland, the revised bereavement support policy will reflect and include input from Shetland Islands Council, Choose Life, Shetland Bereavement Support Service, NHS Shetland Midwifery and Palliative Care.

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
Spiritual Care Policy	D Allan	02/2016 & 07/2016	To meet NHS Scotland, National Guidelines for delivery of Spiritual & Religious Care.

Key Risks to Delivery
The service being professionally single-handed, there is a risk from the lack of financial input in terms of linking the spiritual care lead to the wider spiritual care network throughout NHS Scotland. There must be adequate opportunity for supervision and support on an ongoing basis provided through work time.

Service provision in terms of meeting the needs of patients, families and carers who are acutely unwell is a risk, because the spiritual care lead cannot be as responsive as is necessary. The national standard currently suggest 24/7 provision of support which NHS Shetland does not provide. Limitations of travel and inclement weather is a risk.

Performance Targets with links to National Outcomes
Based on the national and local delivery plans will be constructed both for NHS Orkney and NHS Shetland which will be required for service delivery.

Contact Details

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Further Reading
- CEL (2015) XXXX and The National Delivery Plan for Spiritual Care in Scotland 2015 – 2020 – (Version 10) to be published in 2016.
- Spiritual Care Matters: http://www.nes.scot.nhs.uk/media/3723/spiritualcaremattersfinal.pdf – Tel: 0131 313 8000

- A Multifaith Resource for Healthcare Staff: http://www.nes.scot.nhs.uk/media/3720/march07finalversions.pdf.pdf
- Spiritual and Religious Care Capabilities and Competences for Healthcare Chaplains: http://www.ukbhc.org.uk/sites/default/files/nes_chaplaincy_capabilities_and_competencies.pdf
- The spiritual care lead is involved in a core group from within the larger spiritual care lead group for NHS Scotland to update the Spiritual and Religious Care Competencies to reflect the newly revised CEL (2015) and The National Delivery Plan for Spiritual Care in Scotland 2015-2020 (Version 10) to be published in 2016. All spiritual care guidelines, standards and policies include patients, families, loved ones and carers.

4.8 Staff Development

Policy context

- Joint Development Review (JDR) and Personal Development Planning (PDP)
- Staff Development Policy
- Fire Safety Policy
- Manual Handling Policy
- Policy and Guidelines for the Prevention and Non-Physical Management of Aggression and Violence (PMAV) in the Workplace
- Volunteering Policy

Current Services

- **The Staff and Organisational Development Team** is responsible for: the collation and production of a joint training plan, ensuring the delivery and the co-ordination of key personal and professional training to enable employees across the workforce including those in training to deliver safe and effective care. The department also has a service improvement lead that provides training and project support across Health and Social Care. The Staff and Organisational Development Team are responsible for offering wide range of training covering all areas required by the Board ensuring compliance with statutory requirements. The staff and Organisational Development Team are also responsible for assisting teams achieve targets and objects through specific interventions and for supporting staff with the KSF and JDR programme.
- **The Clinical Education Team** is responsible for creating and maintaining a clinical learning environment for all students. The team also delivers and coordinates a range of clinical training events and programmes to support the aim of appropriately trained staff.
- **The Service Improvement Team** is responsible for providing training and project support across the organisation. The team utilises a range of tools and techniques that are fundamental to getting to grips with the challenges of everyday service delivery and trialling and measuring ideas for change.

Funding and Resources
The Staff and Organisational Development Department receives external funding for a range of posts including the Clinical Development Facilitator and Staff Development Administrator by Robert Gordon University. The Practice Education Facilitator for Nursing, Practice Education Lead for AHPs, Post-Graduate Medical Administrator is all or partially funded by NHS Education for Scotland.

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target across directorate / contribution 2016/17
Staff Development	5.91	344,918	0	344,918	TBC

Needs/Unmet needs/Drivers for change
The Organisational and Staff Development Department delivers high quality education, organisational development and continuous service improvement across NHS Shetland supporting the Board achieving it Corporate Objectives.

Drivers for change include:
Internal

- Local delivery plan
- HR/OD strategy

- Integration – IJB Workforce Development Strategy and Action Plan, Organisational Development Action Plan and Training Plan
- Leadership
- Culture

External

- Quality Strategy
- 20/20 vision
- SGAP
- Staff Survey
- iMatter
- Leadership
- Revalidation

Service Aims/Priorities	Objectives/Actions
Staff and organisational Development	**Compulsory** • Corporate Induction • Induction Refresher • Induction of Temporary Staff • Training Plan • EESS • KSF • Appraisal • iMatter **General** • LearnPro • BCP • Recruitment • Interview skills • E-Learning • Project Management • Volunteers
Service Improvement	• Improvement Methods • Leadership • Change Management • Psychometrics/CER • Integration • Project Management • Project Support • AHP Education • Supervision • Staff Survey
Clinical Education	• Resuscitation • Moving and Handling • Developing the Clinical HCSW • CPD for Nurses, Midwives • Supporting Undergraduate Nurses and Midwives in practice • Mentor support and development

Plans for change

Description	Start date/Comments	Expected Outcome
To support the continued mainstreaming and embedding of the NHS	Update Learning materials to support the continued use of e-KSF and effective JDR	Improvement of uptake by 10%

Description	Start date/Comments	Expected Outcome
Knowledge and Skills Framework (KSF) and Personal Development Review (PDR) process	processes.	
Corporate Induction and Compulsory Refresher Training.	Monitor attendance rates and ensure quality and currency of induction and refresher training.	
Support the delivery of Service Improvement within the Board.	Provide support for projects as requested by the Senior Management Team e.g. localities and pathways projects. Establish a Service Improvement Forum where staff can share knowledge, skills and experiences in a safe learning environment.	
iMatter Staff Experience Tool Implementation	Support the implementation of the programme with Cohort 1, 2 and 3 staff in line with SGHD plan. This includes: Finance, Human Resources and Support Services, Public Health and Performance.	Implementation of all cohorts in 2016 and continuation of rolling programme and improvement cycle.
Board Quality Group	Actions carried out by Quality Working Group - Currently under review	
Transition from registration to revalidation for nurses and midwives	Design and deliver workshops for registrants, confirmers and non registrant managers, support practitioners through process as needs are identified.	All nursing and midwifery staff will successfully complete revalidation process between April 2016 and April 2019 (first round of new process)

The Directorate level actions or most strategically significant operational actions to be delivered are set out in the Directorate Plan and will be monitored each quarter by the Directorate Management Team and Committee Members as part of the quarterly reviews. The key actions for this service are set out in this operational Service plans.

Risks to Delivery
The team is small and carries out a diverse range of actions across the organisation. Risks associated with the outcomes of these actions are:

- Leave
- Vacancies not being filled
- Posts not being renewed
- Capacity

Performance Indicators

Ref	HEAT Measure	Data Available	Period of latest value	Target	Target date	Performance Previous Period
Key: E - Efficiency and Governance -						
BSC8	Knowledge and Skills Framework – Personal Development Plan Review (rolling 12 month figure)	M	2015 Aug	70	31/03/2016	28
BSC9	Staff Survey completion rate	A	2014	50	31/12/2015	38
BSC10	iMatter implementation	A		100	31/05/2015	
BSC12	Number of staff attending mandatory update training sessions 2014-16	M	2015 Aug	540	31/03/2016	314
E.2S	NHS Boards to Achieve a Sickness Absence Rate of 4%	M	2015 Aug	4	31/03/2016	4.18

Contact Details

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Staff and Organisational Development Manager
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5. NHS Plans

5.1 Audiology Service

Policy context
Sensory Impairment Strategy (SEE HEAR) -
http://www.scotland.gov.uk/Resource/0044/00448444.pdf

Scottish Audiology Quality standards -
http://www.scotland.gov.uk/Resource/Doc/270517/0080557.pdf

Locally a 2014 patient survey shows that lack of deaf awareness amongst staff is an issue for patients. (Kathleen Carolan – holds an action plan for this survey). Through 2015 additional funding from SIC to increase support hours from FTE0.6 to FTE 0.4 has allowed for deaf awareness and hearing aid care training to be supplied to SIC and NHS staff. A hearing aid care box has been supplied to each GHB Ward and SIC care home facilities along with other care facilities. Funding for this will stop at the end of December 2015 and impact greatly on the service plans going forward.

The Scottish Healthcare Science National Delivery Plan (2015-2020)
http://www.gov.scot/Resource/0047/00476785.pdf the programme has 5 deliverables.

1. Streamlining health technology management – implement by end of 2020
2. Point-of-care testing – implement by end of 2020
3. Demand optimisation – implement by end of 2019
4. Developing sustainable services – implement by end of 2019
5. A new integrated model for clinical physiology services – implement by end of 2020

The key deliverables for Audiology are 3, 4 and 5.

Current Services
The Audiology service provides Audiological support to NHS Shetland, visiting ENT clinics and the local community.

Hearing assessment, hearing aid provision, hearing aid follow up, hearing aid maintenance and other hearing aid related services. Hearing aid repairs by appointment or by post or drop box at main reception.

Paediatric hearing assessment clinic, hearing aid fitting when required generally for school age children. Babies and pre-school children requiring hearing aid fitting would be seen in Aberdeen with specialist paediatric Audiologists.

Support to the visiting ENT service with the Audiologist working at advanced practitioner level to triage and pre-assess ENT referrals.

Deaf Awareness training to staff of all levels both NHS and SIC

Work with SIC to implement the Sensory Impairment Strategy which has come from the SEE HEAR consultation.

Maintain and improve the services for hearing impaired people both adults and children with a growing elderly population with increasingly complex needs.

Aim to routinely re-design the service to meet changing clinical and financial demands whilst maintain quality of service to patients.

Funding and Resources

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Audiology	1.60	132,659	0	132,659	TBC

As of month 6 (2015) budget statement the non pay part of the budget (61,900) is over spent by £12,815. Due to being a demand led service although efforts are being made to reduce costs it is likely that the service will have an over spend of around £24,000. This will mean not being able to meet the 2% savings target.

Savings plans
5% saving on hearing aid costs from Oticon as main supplier
Recurrent saving of FTE 0.4 Band 4 support post
Redesign of reassessment criteria to reduce the number of self referrals of current hearing aid users. But this may turn out to be futile as time goes on a patients genuinely need re-test and hearing aid upgrade due deterioration in hearing.

Needs/Unmet needs/Drivers for change
There is a growing elderly population with the number of people in the UK rising from 1 in 7 around 20 years ago to 1 in 6 currently. This compares to 1 in 30 who have sight impairment.

There are a significant number of people in the local population with some degree of hearing impairment. Not all will seek help and some will access hearing aids privately but the majority of those suitable for hearing aid provision will be referred for NHS hearing aid provision. We keep a register of active NHS hearing aid users and currently (29th Oct 15) it is 1,108 people. In 2005 there was a list of around 200 Shetland patients supplied from the Aberdeen Audiology service. But this quickly proved to be an underestimate of those using NHS hearing aids at the time. As with all NHS services in recent years who deal with **older people** the demand has begun to increase sharply.

As permanent hearing impairment is a progressive condition the “Scottish Audiology Standards” recommend that this group require review every 3yrs. The Audiology service has not been able to provide this for several years due to lack of capacity within the service.

This group of patients has begun to self refer for review as they notice hearing deterioration which puts them in to the 18week RTT pathway. Further demand comes from the general increase in the older population and increased demand from the ENT service for both Adults and Children. The demand for Paediatric hearing assessment has been steadily increasing for several years.

There is increasing difficulty in supporting elderly hearing aid users who are more likely to have additional complex needs such as dementia and sight loss.

Unmet need
Many hearing aid users do not represent for testing as described above as they may not be aware of the slow deterioration of hearing. Studies have shown that hearing loss can increase problems with dementia and some people have been misdiagnosed with dementia due to hearing loss.

Untreated hearing impairment can cause an already elderly person to become more vulnerable and require more support.

Lack of a second soundproof room to meet demands is becoming more of an issue going forward. This reduces the services ability to re-design and meet the HCS deliverables, 18wks RTT and local targets.

We do not offer an unscheduled service but patients do still turn up without prior arrangement or a scheduled appointment. This can impact on other nearby services such as Physiotherapy and GBH reception staff if patients are no able to access a member staff from Audiology.

Plans for change

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
1. Staffing/Training Assistant Audiological Practitioner post From Sep 2014 funding secured from NES to support all or most of the costs of training this post holder to Associate Audiologist level. Therefore increasing the skill mix	Jackie Haywood	Sep 14 – Jun 16	Diploma in Hearing Aid Audiology (2yrs) online and blocks of study at QMU, Edinburgh. **HCS Deliverable 4** Developing sustainable services
2. Accommodation/ Equipment It has **not been possible** to secure a permanent second clinical room and associated equipment for the Associate Audiologist to work from when qualified. As per previous plan.	Jackie Haywood	ongoing	But measures are in place to use the OH dept room with soundproof booth at most once a week. Along with room availability in outpatients 1 day a week over 2 1/2day sessions. The OH room use is currently on hold due to a new round of direct supervision and log book completion for the 2nd year of diploma. We should be able to utilise the OH room again from May/Jun 2016 but this will be of limited use if the newly qualified Associate Audiologist is still on FTE0.6 rather than FTE1.0 **HCS Deliverable 4** Developing sustainable services
3. Changes to Directorate management structure	Kathleen Carolan	2015-16	Creating a diagnostics lead and therefore a diagnostic group within the directorate. This groups **Audiology**, **Cardiology**, Labs and Medical Imaging. This is a step towards **HCS Deliverable 5** "...develop a sustainable integrated service model to enhance **clinical physiology** service delivery and quality."

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
4. Advanced practitioner The Audiologist works as an advanced practitioner with support to ENT clinics. From Jan 2014 an extended triage of ENT referrals was piloted to help reduce ENT waits/demand.	Jackie Haywood	Pilot from Jan – Jun 14 and now ongoing. Suspended from January 2016 Due to the TAA dropping back to FTE 0.6 there will not be the capacity within Audiology to continue these clinics. **This will impact on the ENT service.**	Outcomes Jan – Apr 14 Discharged 2% (no ENT apt needed) ENT apt needed 65% Hearing aid/Audiology apt needed 33% There is some overlap of patients who need to see ENT after extended triage and also need Audiology input. **HCS Deliverable 4** "...explore new and developing healthcare science roles that support areas of service pressure and have the potential to free-up medical capacity,..."
5. Cochlea implant reviews We have a small number of Shetland patients who have been fitted with cochlea implants at the mainland cochlea implant centre, Lanarkshire.	Jackie Haywood /Diane Coleman (outputs)	From early 2016	These patients have previously travelled to the mainland for assessment/fitting/review. After a pilot in Orkney to offer a review clinic there, we are to set this up for Shetland in early 2016. This will reduce the cost of patients travelling to the mainland. The cochlea implant team will pick up the costs of their travel/accommodation and plan to set this up as a yearly VC type review clinic from 2017 (using the VC facilities in outpatients.) Linked to local aims **of reducing travel costs off island for treatment** which can be provided via telemedicine.

As the Trainee Associate Audiologist (TAA) is still in training and will from January 2016 be going back to FTE 0.6 after a temporary period of FTE 1.0 Jan-Dec 15 as noted in "policy contex". The plans for change are limited as the Audiologist will have to pick up routine clinical tasks formally supported by the TAA from January 2016 at a time of high demand.

Key Risks to Delivery
As per "Drivers for change" the NHS as whole is dealing with **an increasing elderly population who are living longer** and requiring assistance with **more complex needs**. As most of the Audiology service users are older/elderly people this is and will continue to be a risk to delivery of Audiology services.

The service has **1.0FTE Audiologist** who works at advanced practitioner level and so this can make the **service fragile** when this person is not available. Currently demand is regularly

outstripping capacity and although the TAA is training to take on more of the clinical work we **only have one permanent clinical room**.

The new TAA role is increasing the clinical role but the consequence of this is reduced clerical support for the service. We do not have a proper point of contact for patients trying to access the service for unscheduled care. This impacts on other services such as Physiotherapy and main reception.

Costs will rise with **increasing numbers of patients seen and hearing aids fitted**.

Performance Targets with links to National Outcomes
National outcomes/targets
18wks RTT
Scottish Audiology quality standards
Sensory impairment strategy (SEE HEAR)
The Scottish Healthcare science national delivery plan 2015-2020

Service indicators of quality locally – Patient satisfaction survey (usually annually) part of Scottish Audiology quality standards

Contact Details
There is no reception or clerical staff so sometimes people need to leave a message on the answer phone. This can be very difficult for hearing impaired people to be able to use but we also have an email contact.

Audiology Department, Gilbert Bain Hospital, Lerwick, Shetland, ZE1 0TB.
Telephone: 01595 743231 (Audiology office)
Fax: 01595 692184
Email: shet-hb.audiology@nhs.net

We are piloting a link with outpatients to transfer the Audiology phone to them when Audiology staff are seeing patients and not able to answer the phone. (From October 2015)

Further Reading
Sensory Impairment Strategy: http://www.scotland.gov.uk/Resource/0044/00448444.pdf

Scottish Audiology Quality standards:
http://www.scotland.gov.uk/Resource/Doc/270517/0080557.pdf

The Scottish Healthcare Science National Delivery Plan (2015-2020)
http://www.gov.scot/Resource/0047/00476785.pdf the programme has 5 deliverables

Update on Dementia and Hearing Loss:
http://www.hearingreview.com/2014/01/update-on-dementia-and-hearing-loss/

HUB: http://hub.jhu.edu/2014/01/24/hearing-loss-brain-size

5.2 Central Decontamination Unit

Policy Context
CDU provides sterilization and decontamination services from a Unit based at the Gilbert Bain Hospital. The Unit was built in 1996 and has been completely refurbished to meet the current statutory requirements. It is supported by a robust Quality Management System which helps meet ever changing customer requirements in what is a very specialist field.

The Unit provides sterilization and decontamination services for Primary and Secondary Care covering a number of specialities that include Orthopaedics, General Surgery, ENT, Obstetrics, Gynaecology, Ophthalmology, Dental, Maxilla-facial and podiatry.

Staff in CDU provide expert advice on all aspects of sterilization and disinfection, taking great pride in the quality and reliability of the service provided.

Funding and Resources

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Central Decontamination Unit	4.64	166,759	0	166,759	TBC

Needs/ Unmet needs/ Drivers for change
£5000 removed from non pay budget for year 2015/2016 as recurrent savings.

Savings targets of 2% for 2016/2017 from April = £3161 across pay/ non pay budget to be achieved.

Plans for change

Description	Lead officer	Start date/ target date	Expected outcome
Reduction in non pay budget by £5000	Carol Barclay	April 2015	To be taken as recurrent savings
Reduction in B4 Quality Supervisor post by 0.1 FTE to release £2961	Carol Barclay	April 2016	To meet target savings of 2%
Reduction in non pay budget by £200	Carol Barclay	April 2016	To meet target savings of 2%

These saving targets have already been submitted to Finance as part of projected savings for NHS Shetland for the year 2016/ 2017.

Key Risks to Delivery
There is one washer disinfector in the unit that is now eleven years old and spare parts can no longer be obtained for this. This machine needs to be replaced and a request for replacement has been submitted as part of the Capital Management Programme.

The duplex reverse osmosis steam generator for the two sterilizers has had numerous operational issues since installation and commissioning. A bid to link the existing reverse osmosis plant which already supplies the washer disinfectors to the sterilizers to overcome these issues has also been made to the Capital Management Programme.

Both these issues mean that the reliability of decontamination/ sterilization services provided can be interrupted due to breakdowns. Business continuity plans are in place with NHS Grampian for any prolonged breakdowns in service provision.

Performance Targets
NHS Shetland submits data as part of HFS national benchmarking project. This project is still in the early stages of development.

Contact Details
Carol Barclay, Decontamination Lead – GBH Ext 3190
Ruth Black, Production Supervisor – GBH Ext 3191
Angela Hall, Quality Supervisor - GBH Ext 3191

Further Reading
CDU is audited by an external notified body, SGS, on an annual basis to ensure conformity to the Medical Devices Directive 93/42/EEC and to the requirements of 2007/47/EC as well as EN ISO 13485:2012.

5.3 Child & Family Health

Policy context
The Scottish Government's ambition is that Scotland should be the best place in the world for children and young people to grow up. There are a number of national policies and local strategies that we link with to help achieve this ambition and ensure that children and young people who live in Shetland will have the best possible start in life and achieve the best outcomes.

The Refreshed Maternity Framework (2011) has been designed to address all care from conception, throughout pregnancy and during the postnatal period. This document clearly outlines the strategic direction for maternity services in Scotland and NHS Shetland is delivering on this Framework. It has been well recognised that maternal health and wellbeing has a significant impact on future child development and resilience.

The Children and Young People (Scotland) Act 2014 , which was passed by the Scottish Parliament in February 2014 combines proposals to improve the delivery of children's rights and services for children and young people. It is wide-ranging in its focus, building on the foundations of Getting it Right for Every Child (GIRFEC) particularly with the responsibilities outlined for the Named Person/Lead Professional.

GIRFEC is more than the framework supporting inter-agency assessment and planning. It provides the overarching principles and values for everything we do for our children and young people. In order to further embed these into our thinking and practice, we have formulated our practice around the GIRFEC National Practice Model SHANARRI outcomes. All our partner services have adopted this principle. The aim is to bring a common language and framework to all children and young people's services planning.

The Early Years Framework published in December 2008, signified an important milestone in encouraging partnership working to deliver a shared commitment to giving children the best start in life and to improving the life chances of children, young people and families at risk.

The objective of the Early Years Collaborative (EYC) is to accelerate the conversion of the high level principles set out in GIRFEC and the Early Years Framework into practical action.

The aim is to:
- Deliver tangible improvement in outcomes and reduce inequalities for Scotland's vulnerable children
- Put Shetland squarely on course to shifting the balance of public services towards early intervention and prevention by 2016
- Sustain this change to 2018 and beyond

The EYC is premised on the fact that we know there is strong evidence about costs and outcomes of current and desired practice, but much of this is not being used in daily work. Where we have taken on board the evidence, practice does not always reliably recreate what the evidence tells us, and there is inconsistency and patchy implementation.

The EYC will help us close that gap by:
- Creating a structure in which partners can easily learn from each other and from recognised experts in areas where they want to make improvements.
- Supporting the application of improvement methodology to bridge the gap between what we know works and what we do.

There are key change areas identified and the Shetland EYC Group are working with individual teams to deliver improved outcomes for children as described in SOA and Integrated Children's Plan. These include addressing child poverty, family engagement and parenting skills amongst others.

Current Services
The Child Health Team was created in 2012 as a result of bringing together child health services across the community, hospital and specialist settings. The team includes: 1 GPwSi (Paediatrics), 1 team leader, 5.3 Health Visitors, 2 Children's Nurses, 1 School Nurse and a Public Health Staff Nurse who work across Shetland. They are supported by 2 support staff. There are a number of staff who support and work alongside this core team.

- **Health Visitors**
  Health visitors (HVs) support and educate families from pregnancy through to a child's fifth birthday or entering school. Health visitors are trained to recognise the risk factors, triggers of concern, and signs of abuse and neglect in children. HVs also maintain contact with families while formal safeguarding arrangements are in place; ensuring families receive the best possible support during this time.
- **Children's' Nurses**
  Children's nurses have a broad casemix from caring for a neonate to supporting a child following trauma e.g. accident or bereavement. Children's nurses also play a key role in the care and support needed by the wider-family, including the parents. The team includes two Registered Children's Nurses – one with a focus on hospital care and the other is based in the community and provides holistic child centred care to children and young people up to the age of 18 years of age for a wide range of health issues and conditions. The Community Children's nurse may be the Lead professional for children and young people who are identified as needing a Child's Plan as defined by Getting Right for Every Child.
- **Out-Patient Services**
  Our Children's Outpatient Department operates as required and enables children to be seen within Shetland by General Practitioner with Special Interest in Paediatrics and by visiting paediatricians and visiting specialists. Our healthcare support worker works within this department half time and in the school nursing service the rest of her time.
- **School Nurses**
  School nurses are public health nurses who work within a variety of settings but principally within schools. A child-centred public health approach enables the school nurse to work at community level with public health programmes, with whole schools, with group work within schools and with individual children, young people and their families.
- **Children's Physiotherapy**
  The paediatric physiotherapy service is based at the Gilbert Bain Hospital and served by 1.6 FTE staff (made up of 1 FTE Band 7, 0.5 Paediatric band 6, and 0.1 Outpatient Band 6). It provides a service to children and young people aged 0-16 (19 if additional needs) in a variety of settings including: inpatients, outpatients, community and schools.
  The service takes referrals from health, education and also from parents and children themselves via self-referral. It provides advice, assessment and treatment in all areas of paediatric physiotherapy such as development, orthopaedics and musculoskeletal problems, respiratory illness and neurology. It is also able to refer directly into paediatric and orthopaedic clinics for children on the caseload which minimises the impact on GP's.
- **Speech and Language Therapy Service**
  This service provides assessment, diagnosis and treatment for children and adults with speech, language and communication needs, and those with eating, drinking swallowing problems (dysphagia). Children are seen with a range of speech, language and communication needs, including language delay and disorder, difficulties with speech production, voice problems, dysfluency and social communication difficulties. There are 2.56 speech and language therapist and 0.7 support worker. There is currently 243 children on the caseload with 104 referrals in 2013.
- **Child and Adolescent Mental Health Service**
  This multi disciplinary team provides a CAMH service to the population of Shetland. The team consists of 1 FTE Psychiatric Nurse, 1 FTE Primary Mental Health Worker, 0.7 FTE Clinical Associate in Applied Psychology and two visiting specialists – a Consultant Psychologist and a Consultant Psychiatrist – who hold monthly clinics over 4 sessions. It provides consultations, assessments and interventions; treatment can include different types

of individual therapy: behavioural; cognitive; systemic; psychodynamic, family work of various kinds, and where needed prescribed medication. Referral for 2014 has seen a 30% increase in numbers from the same time period in 2013.

- **Children's Occupational Therapist (OT)**
  This service is involved in the assessment and development of the practical skills necessary for children's everyday life. An OT will aim to enable a child to be as independent as possible by analysing the following areas functional abilities, school skills, play skills sensory abilities fine motor gross motor, movement abilities and behavioural responses during your child's day. The staff consist of a specialist children's OT (0.8) Assistant Practitioner (0.5).
- **Medical Care**
  Medical services on island are provided by a local GP with Special Interest in paediatrics and sessional paediatrician providing a community child health clinic, and joint clinics with visiting paediatricians offering a combination of general paediatric sessions and specialist clinics e.g. cardiac, respiratory. Most in-patient children's services are provided through NHS Grampian or to more specialist regional or national paediatric services.
  Children, who are acutely ill, will present through Accident and Emergency, be assessed and given initial treatment by the medical or surgical teams, in consultation with specialist paediatric services in Grampian as appropriate. Children may stay overnight in GBH but if they need longer term inpatient care they will be transferred to a specialist Children's Hospital. There is also a paediatric retrieval service for transporting seriously ill children to specialist units off island.

Funding and Resources

Service	Number of Staff (FTE) [9]	Expenditure	Income	Net Budget	Savings target [10]
Child Health	28.98	1,359,669	0	1,359,669	TBC

The indicative savings target for planned care services in 2016-17 is **£42,470.** This is equivalent in staffing costs to a reduction of FTE 1.3 Band 5 (midpoint) in the establishment across the budgets identified. The focus is not on top slicing staffing costs to make savings but rather the identification of ways in which we can:

- review skill mix including advanced practice NMAHP role development and other skill mix changes
- Repatriating services e.g. obstetrics and gynaecology to reduce patient travel and the cost of off island services

Needs/Unmet needs/Drivers for change

- Due to the changes in medical training recruiting medical consultants who have the expertise to care for children may be problematic in the future.
- A national shortage of Health Visiting staff and the implementation of the Children and Young Peoples Act have led to a government-led initiative to increase the number of health visiting posts Scotland wide with a new training programme starting and an increase in the number of Health Visiting posts rising over the coming years.
- In terms of the Shetland workforce, 60% of Health Visitors in post are due for retirement in the 3-5 years
- Modernisation of the school nursing role is at an early stage and the outcome of that consultation may have an impact on the service we provide in the future
- CAMHS require redesign options discussed to ensure the service can accommodate the increase and diversity of the children being supported by the staff

[9] Establishment is taken from 2015/16 workforce plans

[10] Applied as 3% savings to each budget area – most savings will be made against schemes rather than top slicing from individual budget areas

- Advance Practice models for AHP is being discussed nationally. We need to look at the potential of advanced practice NMAHP roles to support children's services locally

Plans for change

- The impact of the Children and Young Person's Act 2014 and the new HV pathway needs to be quantified and evaluated over the next few years – including the workforce needed to deliver the legal requirements of the act
- Redesign of the CAHMS team and links to specialist services is a key priority
- On-island paediatric outpatient care is fragile. A review of the options available to sustain input from medical specialist team will be required over the next 1-2 years
- Joint commissioning and joint budgeting discussions are being tabled at the Integrated Children and Young Person's Strategic Planning group (ICYPSPG). We will be engaging with this work over the coming years
- The move to an electronic child's record will allow the secure sharing of information between services when required under the Children and Young Person's Act (2014)

Key Service Indicators - HEAT and other Local Targets

ID Code	Target Description
H.9	3 and 4 year old children in each SIMD quintile to receive at least two applications of fluoride varnish (FV) per year (percentage)
H.10	At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation by March 2015 so as to ensure improvements in breast feeding rates and other important health behaviours. (percentage)
BSC4	Immunisation Uptake - MMR1 at 2 yrs (percentage)
BSC7	Percentage Uptake of Breastfeeding at 6-8 Weeks (exclusively breastfed plus mixed breast and formula) (Rolling annual total by quarter) (percentage)
HI.3	Percentage of mothers smoking during pregnancy
HI.4	Reduce the proportion of children with their Body Mass Index outwith a healthy range (>=85th centile) (percentage)
HI.6	Reduce teenage pregnancy rate (13-15 year olds) Rate per 1,000 population (3 year rolling average) (rate)

Service Performance Measures from the Shetland Single Outcome Agreement

Single Outcome Agreement objectives:

- Effective early intervention and prevention to enable all our children and young people to have the best start in live.
- Effective early intervention and prevention to get it right for every child.

Other Performance indicators

National Performance Framework strategic objectives:

- Our children have the best start in life and are ready to succeed.
- We have improved the life chances for children, young people and families at risk.
- Our young people are successful learners, confident individuals, effective contributors and responsible citizens.

EYC aims are:

- To ensure that women experience positive pregnancies which result in the birth of more healthy babies as evidenced by a reduction of 15% in the rates of stillbirths (from 4.9 per 1000 births in 2010, to 4.3 per 1000 births in 2015) and infant mortality (from 3.7 per 1000

live births in 2010, to 3.1 per 1000 live births in 2015). This objective has been achieved and a review is underway to establish further aims in this area.
- To ensure that 85% of all children within each Community Planning Partnership have reached all of the expected developmental milestones at the time of the child's 27-30 month child health review, by end-2016.
- To ensure that 90% of all children within each Community Planning Partnership have reached all of the expected developmental milestones at the time the child starts primary school, by end-2017.

Local outcomes (as agreed by the Integrated Children and Young Peoples Strategic Planning Group in the Multiagency Children's Plan):

- Shift from crisis intervention to prevention and early intervention.
- Promote resilience and wellbeing of children, young people, families and communities.
- Timely engagement with children and young people to ensure their views shape current and future planning.
- Continue development of our workforce in delivering the best outcomes for children and young people through their multi-agency working.

Contact Details
Kate Kenmure – kate.kenmure@nhs.net

Further Reading
GIRFEC website: http://www.shetland.gov.uk/children_and_families/GIRFEC.asp

EYC website: http://www.scotland.gov.uk/Topics/People/Young-People/early-years

Shetland Integrated Children and Young People Plan:
http://www.shb.scot.nhs.uk/board/documents/icyp-20142017.pdf

5.4 Laboratory

Policy context
To comply with UKAS accreditation standards it is essential to maintain the current clinical governance relationship with NHS Grampian.

The current obligate network arrangements with NHS Orkney have allowed shared management and quality management roles across both island sites. An extension of these arrangements permits the provision of a managed service agreement for laboratory equipment across both sites, thus providing operational resilience and efficiencies to both boards.

Current Services
The Laboratory Services is by design a multi discipline service covering Haematology, Biochemistry, Microbiology and Blood Transfusion whose main services are described below. No Cellular Pathology, post mortem & mortuary services are provided in Shetland – all histology and cytology samples are referred to NHS Grampian laboratories.

This is provided 24/7 by a combination of rostered shifts and OOH on-call service to NHS Shetland acute services (GBH) and primary care providers (GPs). Service levels are defined by NHS Scotland – Remote & Rural district general hospital.

Clinical Biochemistry department
The clinical biochemistry department provides an acute/routine service for both primary and secondary care throughout NHS Shetland. The bulk of the workload is carried out on a Beckman Coulter DxC600i chemistry analyser. NHS Grampian Directorate of clinical pathology laboratories undertakes more specialised testing as per a service level agreement. By having sample deliveries to Aberdeen three days a week and automated electronic reporting each day it is possible to deliver a comprehensive service to meet the needs of NHS Shetland.

Haematology and Blood Transfusion department
The haematology department provides a routine Full Blood Count (FBC), coagulation and haematinic service. The blood transfusion service in Shetland acts as a peripheral blood bank to the north east of Scotland the regional transfusion centre. The laboratory holds agreed levels of blood components required for the needs of Shetland.

Although the blood transfusion related work is a relatively small proportion of the overall clinical laboratory workload, the importance is crucial to the community of Shetland. The Hospital Transfusion Committee (HTC) plays a key role in producing effective and robust procedures for transfusion within the Gilbert Bain hospital. The minutes of HTC meetings are available within the blood transfusion laboratory.

Microbiology department
The department provides a routine microbiology service to Shetland. The laboratory carries out routine culture and antibiotic sensitivities and environmental monitoring for the Central Decontamination Unit (CDU). Isolates are generally identified to species level, if further investigations are required; they are referred to the appropriate reference laboratory. Samples and isolates that require higher than containment level two are referred to appropriate CPA/UKAS accredited laboratories usually within NHS Grampian.

Funding and Resources

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Laboratory	9.62	761,461	0	761,461	TBC

Needs/Unmet needs/Drivers for change
World-wide laboratory requests for laboratory investigations show a universal long run universal average annual increase of 7% per annum. The annual increase in NHS Shetland from calendar year 2012 to 2013 was 6.4%. This continuing increase in demand has both financial and operational implications; financial due to continuing need for adjustments to budget for laboratory consumables (test reagents) and operational, to cope with increases in demand – a combination of more labour, larger machines or faster machines is required.

Both island Boards, Orkney and Shetland suffer from a lack of resilience in their current analyser plant. Both biochemistry analysers are beyond their economic life and are overdue for replacement, the same is true for the coagulation analysers, and there is limited point of care test (POCT) capability. These issues are being addressed by the joint managed service contract (MSC) for laboratory services.

Plans for change

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
1. Severe difficulties in recruitment of specialist BMS staff 2. Obsolete and archaic equipment, well beyond expected economic life 3. No effective POCT capability 4. Restricted governance capability/capacity 5. Limited use of IT connectivity: – lab-lab & lab order-comms	Director Acute Services & laboratory manager	1. Ongoing 2. Jan 2016 3. Mar 2016 4. Ongoing 5. Not known	

Key Risks to Delivery
The total lack of analyser back-up is an important risk to the resilience of the service – this to be addressed by the MSC.

As with all small organisations, difficulty in the recruitment of specialist scientific staff is frequently problematic. To date, the laboratory has always eventually managed to recruit, and retain, sufficient qualified and registered staff, however there have been, in the past, significant gaps between resignation and recruitment. The option of short term locum staff to “back-fill” must always be retained.

Performance Targets with links to National Outcomes
TBC

Contact Details
Laboratory manager: Geoffrey Day, Phone 01595 743000 x3041
Quality manager: Carina Campos-Rio Phone 01595 743000 x3041
Laboratory reception: Direct dial Phone 01595 743011

5.5 Medical Imaging

Policy Context
The AHP national plan (2012) and the Healthcare Science National Plan (2015) are key policies which shape the scientific professions aligned to healthcare. Other policy areas include the review of service sustainability particularly the reform necessary to support sustainable workforce and safe, seven day service provision. The contribution of clinical support services is described in local strategies and plans e.g. the older people's strategy (2015), integration fund plan (2015-16, refreshed annually), corporate action plan (2015-16, refreshed annually), unscheduled care plan (2015-16) and winter plan (2015-16, refreshed annually).

Our high level aims to support the delivery of clinical support services, which are also aligned to the AHP and Healthcare Science National Plans include ensuring that we deliver:

- Clinically Focussed and Empowered Diagnostic/Clinical Support practitioners
- **Ensure clinical pathways are evidence based and diagnostic tests are evidence based**
- **Seven day services are appropriately targeted to reduce variation in weekend and Out of Hours working**
- **Sustainable services and develop our local workforce – including fellowship and development posts to build resilient local teams**

Current Services Provided
The team consists of 6 Radiographers, 1 Sonographer, 1 Imaging Assistant and 1 Imaging Services Administrator.

The medical imaging department[11] undertakes approximately 14,000 imaging examinations per year. There is no local Consultant Radiologist and Radiologists at NHS Grampian, Aberdeen Royal Infirmary carry out reporting, where the Clinical Director is also based. Consultant Radiologists visit the department once a month to carry out specialised examinations. Role extension is actively encouraged within the department.

Key modalities available locally include plain film imaging/fluoroscopy/mobile/CT scanning & Ultrasound. There is out of hours emergency cover provided by a single on call radiographer. Modalities therefore available out of hours are dependent on the scope of practice of the radiographer on call.

The department operates highly efficiently by offering plain film imaging on demand; not only for A&E referrals, but for all primary & secondary care referrals where possible. Appointment systems operate for ultrasound and CT scanning due to the nature of the examinations which require preparation.

Funding & Resources

Service	Number of Staff (FTE) [12]	Expenditure	Income	Net Budget	Savings target [13]
Medical Imaging	8.96	663,449	0	663,449	TBC

[11] Medical imaging is a clinical support service and one of the 'visible other' services out with the Integration Scheme strategic remit but provides services to practitioners which are part of 'side aside' and 'managed services'.

[12] Establishment is taken from 2015/16 workforce plans

[13] Applied as 3% savings to each budget area – most savings will be made against schemes rather than top slicing from individual budget areas

Drivers for Change
Over recent years, services that clinical support and diagnostics have been under increasing pressure. There are a number of factors which have caused these pressures:

- A growing elderly population with increasing and complex health and social care needs
- Increasing public expectation of and access to health and social care services
- Increasing demand for diagnostic tests and the need to ensure that there is a clear evidence base for test requests
- Challenges in training, recruitment and retaining of staff

Plans for Change
The indicative savings target for unscheduled services in 2016-17 is £19,903. This is equivalent in staffing costs to a reduction of FTE 0.5 Band 5 (midpoint) in the establishment across the budgets identified. The focus is not on top slicing staffing costs to make savings but rather the identification of ways in which we can:

- Streamlining pathways – reducing the number of diagnostic tests by creating a more consistent approach and evidence based pathways for diagnostic testing
- Increasing the number of diagnostic tests available locally – reducing off island service level agreement costs (e.g. looking at the potential to bring MRI to Shetland)
- Reduce inefficiency and short term spending on locum/supplementary staffing by changing the skill mix in teams

Our strategic priorities for medical imaging services as set out in the Corporate Action Plan (2015-16 and beyond) and the Capital Plan (2015 and beyond) as well as the various strategies referenced above can be summarised as follows:

- Role development to diagnostic/clinical support service delivery – particularly the positioning of advanced NMAHP practitioners to support local and regional shared services as well as looking at the development of the Assistant Practitioner role
- Ensuring that there is appropriate investment in medical imaging technology to support the repatriation of diagnostic tests from specialist services and ensure that we can sustain the delivery of local services

Description	Lead Officer	Start date/target	Expected Outcome(s)	National Outcomes
Reviewing the medical imaging staffing skill mix and team structure	Head of Medical Imaging/ Director of Nursing & Acute Services (DNAS)	Ongoing from 2015	Improvement management capacity to support service delivery Improved skill mix (ratio of professional management to clinical management roles) Reduced management costs	Resources are used effectively and efficiently
Diagnostic Imaging Equipment Replace Programme - Replacement of x-ray equipment (2017-18) Replacement of CT scanner (by 2021) Replacement of current ultrasound machine (by 2018)	Head of Medical Imaging	Ongoing from 2015	Increased opportunity for new technologies/modalities of diagnostic testing which might be less invasive or potent (e.g. radiation levels) Increased opportunity to provide local diagnostics to support clinical pathways in Shetland (including repatriation of services)	Resources are used effectively and efficiently People using services are safe from harm

Key Risks to Delivery
Key issues (as set out in various local strategies/corporate action plan etc) include:

- Impact of local HB plans to repatriate services locally and increases in diagnostic testing generally have put pressure on all clinical support services and diagnostic modalities such as ultrasound have seen significant increases in demand
- A recent needs assessment for ultrasound services depicted a requirement to increase sonographer staffing to meet current demand and we have trained additional staff to help match this demand. However, we will need to keep a watching brief on increasing demand in terms of workforce planning and development and expansion of the service. A business case has been put together proposing expansion of the existing ultrasound facilities which will be progressed if no other solution to meet service needs is identified
- Expectations towards delivery of 7 day working in remote and rural services – we have reviewed the models of clinical support service delivery and an on call model is the most sustainable way of providing 24/7 access to diagnostic tests. However, this may not align with national standards for the delivery of 7 day services, but alternative models for remote and rural service provision might not be available (e.g. reporting can be part of a shared service model with remote decision making, but a Radiographer is still required to undertake the diagnostic test and where services have diseconomies of scale, moving to 7 day service delivery for ultrasound would be challenging).

Targets/Outcomes
There are a number of HEAT targets that specifically relate to quality or performance markers for effective medical imaging services and they are summarised below with a snapshot of the Performance Dashboard (October 2015).

Ref	Target Description	Freq	Period last	Perf	Period current	Perf	RAG	Vs last	Traj	Target Date	End Target
Acc5	Number of cases where the ultrasound scan waiting time was greater than 6 weeks (count)	M	2015 Aug	0	2015 Jul	0	**G**	→	0	2016-03	0
Acc6	Number of cases where the CT scan waiting time was greater than 6 weeks (count)	M	2015 Aug	0	2015 Jul	0	**G**	→	0	2016-03	0
Acc7	Number of cases where the Barium enema test waiting time was greater than 6 weeks (count)	M	2015 Aug	0	2015 Jul	0	**G**	→	0	2016-03	0

Contact Details
Ann Smith
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Email: annsmith5@nhs.net

Further Reading
Medical Imaging Department intranet page
Royal College of Radiologists: https://www.rcr.ac.uk/
Society of Radiographers: https://www.sor.org/
Grampian Radiation Protection Service/website:
http://www.gov.scot/resource/0039/00395491.pdf
Healthcare Science Delivery Plan (2015): http://www.gov.scot/Resource/0045/00453441.pdf

5.6 Physiological Measurements

Policy context
Following the Healthcare Sciences Delivery Plan it is hoped that resource will become available to help streamline the current demand led service.

Current Services
Physiological Measurements provides mainly cardiac physiological measurement services to NHS Shetland and the local community.

The service is multifunctional with diagnostic services in the main along with treatment services for patients with implanted cardiac devices.

The service aims is to provide physicians with data to guide treatment as well as treating patients with implanted cardiac devices to maximise their function.

Funding and Resources

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Physiological Measurements	1.0	66,616	0	66,616	TBC

Needs/Unmet needs/Drivers for change
National changes in the patient demographic not only result in an increase of patients surviving to an older age but also result in an increase of patients with conditions of older age along with technology that can treat these patients. For example Aortic Stenosis – in the past a simple echocardiogram to determine the condition and measure a single number to guide treatment took about 20 minutes. Today that test requires more parameters such that 60 minutes is not unusual. That and in the future, more information will be required as there are now surgical treatments for those older patients who were just treated palliatively.

While numbers may not increase dramatically in Shetland, the time per patient will.

Reducing employment cost is a massive driver for change. The nominal retirement of the present incumbent is the end of 2016/17. And while this is an opportunity to redesign the service it is against a background of shortages of appropriately qualified and sufficiently skilled cardiac physiologists in the UK

Plans for change

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
SERVICE REDESIGN AS PART OF RETIREMENT OF PRESENT INCUMBENT Current draft model: Grampian to provide implanted cardiac device follow-up service Employ a BSE accredited echocardiographer Move community services done in the hospital to the community eg Spirometry and	KATHLEEN CAROLAN	JAN 2015 ONWARDS To be in place end 2016	CONTINUED SAFE AND APPROPRAITE CARDIAC PHYSIOLOGY SERVICE FOR SHETLAND Seamless service provided by appropriately qualified and experienced cardiac physiologists Community testing closer to the patient

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
ABP Investigate arrhythmia service			

Key Risks to Delivery
Financial risks are involved with requiring increased investigations for an aging population. Eventually capacity will overwhelm supply and further practitioners may be needed.

Already bank staff are being used to supply chaperoning services to avoid females having a longer wait time than males for echocardiography.

The shortage of appropriately qualified and experienced echocardiographers - a package to recruit and retain will most likely be higher financially than for the present incumbent.

Weather and travel costs for the visiting implanted cardiac devices service.

Still a single-handed practitioner.

The present incumbent is paediatric trained and it may not be possible to source a future clinical physiologist with a broad skill base.

Contact Details
Physiological Measurements is situated in the GBH.
Contact Chris Brown 01595743053.
Email chrisbrown3@nhs.net

5.7 Planned Care

Policy Context
Planned care is an umbrella term used to describe services which are planned and pre-booked by appointment. This includes access to elective procedures in Day Case and Ambulatory Care settings, access to diagnostic tests and outpatient consultations.

The overarching aim of services aligned to planned care activities is to provide safe, effective and person centred care for patients who are presenting to health or social care services for pre-booked assessments, tests, care and procedures. Planned care takes place across community, hospital and specialist settings.

The national policy context is very broad and includes: the Public Bodies (Joint Working) (Scotland) Act (2014); 20:20 Vision (2011) and the Patients Rights Act (2011).

Other policy areas include the review of service sustainability particularly the reform necessary to support sustainable workforce and safe, seven day service provision. The importance of planned care services is described in local strategies and plans e.g. the older people's strategy (2015), dementia strategy (2015), mental health strategy (2013), integration fund plan (2015-16, refreshed annually), corporate action plan (2015-16, refreshed annually), unscheduled care plan (2015-16) and winter plan (2015-16, refreshed annually).

Our high level aims to support the delivery of planned care services, which are also aligned to local policy context, include:

- Streamlining referral and diagnostic pathways
- Active management of admissions so that only patients who need specialist care are admitted to hospital (implementing alternative models, reducing length of stay)
- Active management and redesign of outpatient services (e.g. developing multi-disciplinary models, introducing telehealth to support remote access etc) to promote pre-admission assessment and follow up in localities
- Creating pathways to support day surgery and ambulatory care as the norm for planned procedures (reducing reliance/pressure on inpatient services)

Current Services Provided
The majority of healthcare services have a planned care pathway, but the main ones can be defined[14] as:

- Day Surgery Services
- Out Patient Services (local and visiting)
- Pre-Operative Assessment Services
- Chemotherapy Services
- **Renal Services**
- **Elective Inpatient Medical Services**
- Elective Inpatient Surgical Services
- **Elective Rehabilitation Services**
- Planned Critical Care Services (e.g. pre-operative optimisation and post operative care)
- Elective Theatre Services
- Elective Obstetric Services e.g. pre and post natal care, planned c-sections
- Elective Service provision at NHS Grampian for patients requiring specialist interventions
- Allied Health Professionals - AHPs (planned clinics are in place across all seven AHP disciplines)
- Diagnostic Services (e.g. Medical Imaging, Laboratory Services, Audiology, Physiological Measurements etc)

[14] The services shown in bold are part of the joint service planning arrangements set out in the Integration Scheme – known as part B 'set aside' services.

In addition to this, NHS partners such as NHS24 and the Scottish Ambulance Service (SAS) play a critical role in the co-ordination of planned care, including the provision of tele-health services to support long term conditions and self management as well as transporting patients between health and social care settings.

Separate plans have been produced which set out diagnostic service provision (e.g. Medical Imaging and Laboratory Services) as they operate across acute and community services and support specialist, planned and unscheduled care delivery. Child and Family Health Services are also shown in separate plans.

A range of specialist NHS services are provided to Shetland residents by Scottish mainland NHS (off island), through Service Level Agreements (SLAs) primarily with NHS Grampian, also as regional and national specialties with Boards across Scotland. This costs the Board around £7 million per year. Change is agreed through specialist service commissioning at national level via the National Specialist Services Committee (NSSC) and regionally via North of Scotland Planning Group (NoSPG).

Funding & Resources
Other Planned Care Services & Support Functions in the Acute & Specialist Services Directorate

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Planned Care	75.50	5,219,060	530,583	4,688,477	TBC

Drivers for Change
Over recent years, services that provide planned care have been under increasing pressure. There are a number of factors which are associated with the increase in planned care activity including:

- A response to demands associated with demographic changes and patterns of ill health
- Increased public expectation of equity of access to health and social care services
- Advancement in technology, diagnostic capabilities and surgical techniques has made many interventions safer and less invasive resulting in an increase in the number of patients eligible for treatment
- Progressive shift towards the delivery of day case surgery, interventions and diagnostic tests in ambulatory care units and out with the hospital setting
- Successful delivery of services within the national waiting times treatment guarantee (TTG) and other access targets

Another important factor impacting on planned care delivery and is a key driver for change is the relationship between planned and emergency care services. Wherever possible, planned and emergency care should be streamed separately to reduce the impact of cancellations when emergency care services in particular, are under pressure. This can be very challenging to achieve, because our clinicians are generalists and so support both elective and emergency care pathways.

National and local priorities are aligned to meeting these challenges through a focus on:

- Health improvement and self management strategies
- Managed Clinical Networks (MCNs) to support people with long term conditions e.g. diabetes, cancer, neurological conditions, sensory impairment
- Promoting personal and community level resilience and accountability for health and wellbeing
- Effective health and care pathway design across primary, secondary and specialist care
- Delivering Outpatient Integration Together (DO IT)
- The Patients Rights Act – Treatment Time Guarantee (TTG)
- Making ambulatory care and day care services the norm
- Effective models of unscheduled care delivery

Plans for Change
The indicative savings target for planned care services in 2016-17 is £333,209. This is equivalent in staffing costs to a reduction of FTE 10.5 Band 5 (midpoint) in the establishment across the budgets identified. The focus is not on top slicing staffing costs to make savings but rather the identification of ways in which we can:

- Reducing our reliance on expensive inpatient beds and focusing on ambulatory care models
- Increase efficiency and productivity e.g. by delivering more services locally using affordable methods such as tele-health
- Streamlining pathways – reducing the reliance on outpatient services and delivering more complex assessments with practitioners in the community
- Reduce inefficiency and short term spending on locum/supplementary staffing

Our strategic priorities for planned care as set out in the Corporate Action Plan (2015-16 and beyond) and the various strategies referenced above can be summarised as follows:

- Managing patient flow - balancing planned and emergency care and separating flows wherever it is possible to do so
- Developing new models of supported rehabilitation, discharge to enhance recovery and reduce length of stay in hospital
- Repatriating services where it is safe to do so – providing person centred care and maximising the efficiency of local services
- Developing ambulatory care and day care models as a safe alternative to inpatient care and increasing activity through investment in ambulatory care and day surgical facilities
- Using technology and tele-health to avoid unnecessary follow up/review in hospital
- Role development to support planned care service delivery – particularly the positioning of advanced NMAHP practitioners in ambulatory care and outpatient settings
- Reducing the number of people who are delayed in hospital

Some of the specific change management plans/actions/impact and timescales are shown here.

Description	Lead Officer	Start/Target	Expected Outcome(s)	National Outcomes
Increasing access to tele-health appointments to avoid unnecessary follow up and travel	Director of Nursing & Acute Services (DNAS)	Ongoing from 2015 – review progress September 2016 and annually thereafter	Increase in use tele-health delivered appointments Increase in electronic triage of referrals Reduction in the cost of patient travel	Public services contribute to reducing health inequalities Resources are used effectively and efficiently
Increasing capacity in the renal unit to meet demand	Director of Nursing & Acute Services (DNAS)	Ongoing from 2015 – review progress September 2016 and annually thereafter	Additional renal dialysis stations – to meet growing service demand Reduced patient travel through the provision of teleheath	Resources are used effectively and efficiently
Identifying appropriate clinical pathways for repatriation to Shetland in collaboration with NHS Grampian – e.g. local surveillance instead of specialist service oversight,	Director of Nursing & Acute Services (DNAS)	Ongoing from 2015 – review progress September 2016 and annually thereafter	Reduction in the number of patients travelling to NHS Grampian and other hospitals for follow up Reduction in the number of procedures undertaken in NHS Grampian hospitals Reduction in the cost of the SLA (at a sub speciality	Public services contribute to reducing health inequalities Resources are used effectively and efficiently

Description	Lead Officer	Start/Target	Expected Outcome(s)	National Outcomes
shared pathways with specialists in Grampian			level)	
Developing an enhanced Day Surgical Unit (DSU) and ambulatory care facility	Director of Nursing & Acute Services (DNAS)	Ongoing from 2015 – if funding is successful then construction will be complete mid 2017	Increase in the number of day case surgical procedures (through repatriation of clinical services from Grampian) Increase in the number of ambulatory care procedures (as an alternative to admission) Reduction in the number of inpatient attendances and outpatient attendances Reconfiguration of inpatient services/beds (medium term)	Public services contribute to reducing health inequalities Resources are used effectively and efficiently
Review NMAHP skill mix to support sustainable workforce (incorporating the medical staffing review)	Director of Nursing & Acute Services (DNAS)	Scoping exercise 2015-16 Options selection and implementation 2016-17 onwards	Increased role development for NMAHPs with advanced practice skills Increased number of NMAHPs supporting planned care e.g. in outpatient setting Reduced length of stay (LoS) for patients due to increased availability of enhanced recovery models Reduced LoS linked to nurse led discharge Reduced locum costs (e.g. for junior doctor vacancies)	Resources are used effectively and efficiently H&SC services are centred on helping to maintain or improve quality of life People using services are safe from harm
Put in place a managed service contract for Laboratory Services (joint arrangement with NHS Grampian and NHS Orkney)	Director of Nursing & Acute Services (DNAS)	Ongoing from 2015 – review implementation in September 2016	Fixed costs for revenue requirements for lab reagents Reduced capital costs for laboratory equipment replacement and maintenance Reduced cost of on call for BMS staff (moving towards point of care testing and sample analysis automation)	Public services contribute to reducing health inequalities Resources are used effectively and efficiently
Reviewing the management structure for Acute & Specialist Services	Director of Nursing & Acute Services (DNAS)	Ongoing from 2015 – review implementation in September 2016	Improvement management capacity to support service delivery Improved skill mix (ratio of professional management to clinical management roles)	Resources are used effectively and efficiently

Description	Lead Officer	Start/Target	Expected Outcome(s)	National Outcomes
			Reduced management costs	

Key Risks to Delivery

Key issues (as set out in various local strategies/corporate action plan etc) include:

- Planned care is a complex series of inter-related services and pathways – it is critical that service redesign forms part of a 'whole system' strategic exercise with all partners working to shared objectives
- Pace of change – e.g. developing primary care and locality based alternatives to outpatient assessment, review clinics and early supported discharge will take time. We need to ensure that acute service delivery can be safely sustained whilst service redesigns are completed and new models developed and implemented
- Viability of alternative models – we will need to work closely with specialist services and NHS partners to ensure that pathway redesign is realistic and deliverable. There are considerable challenges ahead for succession planning generalist clinical roles and we are already starting to see the impact of this on some visiting services
- Increase in demand for acute services due to demographic changes and case complexity
- Rising costs associated with increases in demand and inflation reduce the impact of the redesign plans

Targets/Outcomes

There are a number of HEAT targets that specifically relate to quality or performance markers for effective planned care systems and they are summarised below with a snapshot of the Performance Dashboard (October 2015).

Ref	Target Description	Freq	Period last	Perf	Period current	Perf	RAG	Vs last	Traj	Target Date	End Target
E.4.2S	Total Delayed Discharges (count)	M	2015 Aug	2	2015 Jul	2	**R**	→	0	2016-03	0
E.9	No people will wait more than 14 days to be discharged from hospital into a more appropriate care setting, once treatment is complete, excluding complex needs codes (count)	M	2015 Aug	0	2015 Jul	0	**G**	→	0	2016-03	0
A.9aS	Urgent Referral With Suspicion of Cancer to Treatment Under 62 days (percentage)	M	2015 Jul	83	2015 Jun	100	**R**	↓	100	2016-03	95
A.9bS	Decision to treat to first treatment for all patients diagnosed with cancer - 31 days (percentage)	M	2015 Jul	100	2015 Jun	100	**G**	→	100	2016-03	95
A.10.2Sa	Number of patients waiting more than 12 weeks from referral to a first outpatient appointment (consultant led services) (count)	M	2015 Jul	38	2015 Jun	21	**R**	↓	0	2016-03	0
A.10.2Sb	Inpatients/Day Cases Waiting Over 9 Weeks (count)	M	2015 Jul	11	2015 Jun	9	**R**	↓	0	2016-03	0
A.10.2Sba	Treatment Time Guarantee - 12 weeks from being added to	M	2015 Jul	0	2015 Jun	0	**G**	→	0	2016-03	0

Ref	Target Description	Freq	Period last	Perf	Period current	Perf	RAG	Vs last	Traj	Target Date	End Target
	Inpatient waiting list to having procedure (count)										
A.10.2Sc	Number of patients waiting more than 12 weeks from referral to a first outpatient appointment (Orthodontic Service) (count)	M	2015 Jul	1	2015 Jun	0	**R**	↓	0	2016-03	0
A.10S	18 Weeks Referral to Treatment: Combined Performance (percentage)	M	2015 Jul	93.5	2015 Jun	94.8	**G**	↓	90	2016-12	90
Acc1	Number of cases where the Upper GI endoscopy waiting time was greater than 6 weeks (count)	M	2015 Aug	0	2015 Jul	1	**G**	↑	0	2016-03	0
Acc2	Number of cases where the Lower endoscopy (excluding colonoscopy) waiting time was greater than 6 weeks (count)	M	2015 Aug	0	2015 Jul	0	**G**	→	0	2016-03	0
Acc3	Number of cases where the colonoscopy waiting time was greater than 6 weeks (count)	M	2015 Aug	0	2015 Jul	0	**G**	→	0	2016-03	0
Acc4	Number of cases where the cystoscopy waiting time was greater than 6 weeks (count)	M	2015 Aug	0	2015 Jul	0	**G**	→	0	2016-03	0
Acc5	Number of cases where the ultrasound scan waiting time was greater than 6 weeks (count)	M	2015 Aug	0	2015 Jul	0	**G**	→	0	2016-03	0
Acc6	Number of cases where the CT scan waiting time was greater than 6 weeks (count)	M	2015 Aug	0	2015 Jul	0	**G**	→	0	2016-03	0
Acc7	Number of cases where the Barium enema test waiting time was greater than 6 weeks (count)	M	2015 Aug	0	2015 Jul	0	**G**	→	0	2016-03	0
BSC16	Quarterly Hospital Standardised Mortality Ratios (HSMR) (count)	Q	2015 Jan-Mar	0.61	2014 Oct-Dec	1.27	**G**	↑	1	2016-03	1
T.12	Emergency bed days rates for people aged 75+ (rate))	M	2015 Aug	361	2015 Jul	421	**G**	↑	500	2016-03	3497
T.14	To increase the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer by 25%. (percentage)	A	2014	19.2	2013	16.4	**R**	↑	26	2016-03	29
CCB1	Average length of stay for critical care patients discharged per month (days)	M	2015 Jul	2	2015 Jun	1.9	**G**	↓	2	2014-12	2
CE02a	% of people who say they got the outcome (or care support) they expected and needed on Ward 3 (percentage)	M	2015 Jul	100	2015 Jun	100	**G**	→	90	2016-03	90
CE02b	% of people who say they got	M	2015	100	2015	100	**G**	→	90	2016-	90

Ref	Target Description	Freq	Period last	Perf	Period current	Perf	RAG	Vs last	Traj	Target Date	End Target
	the outcome (or care support) they expected and needed on Ward 1 (percentage)		Jul		Jun					03	

Contact Details
Kathleen Carolan, Director of Nursing & Acute Services, kcarolan@nhs.net

Further Reading (available at http://www.shb.scot.nhs.uk)
Older Peoples Strategy

Corporate Action Plan

Unscheduled Care Strategic Plan

5.8 Public Health

Public Health covers the three domains of health improvement, health protection and population health in service planning and delivery. Further detail on Health Improvement is included in that separate section of the Strategic Plan. his section focuses on the core Public Health Team, and policy and service change etc in core public health, health protection and population health. (However, for the purposes of meeting financial savings targets, both the Public Health and Health Improvement departments are included in the Public Health Directorate overall budget and savings budget, so the likely impact of these on both Public Health and Health Improvement is included here.)

The Public Health team work to deliver the requirements of the Public Health Etc (Scotland) Act 2008, which governs the requirements and arrangements for public health in Scotland.

Current Services
The Public Health Department provides public health services to NHS Shetland and the local community. Our purpose is to promote, improve and protect the health and wellbeing of the people of Shetland, to prevent ill-health, and to reduce health inequalities. We do this by surveillance and response to communicable disease and environmental health threats, and oversight of immunisation and screening programmes; health improvement programmes targeted at lifestyle factors, working with individuals and communities on prevention and tackling inequalities; and technical support on population health through health intelligence work, needs assessment, health impact assessment and service evaluation.

The Public Health Directorate includes the core Public Health Team and the Health Improvement Team.The current core Public health Team consists of:

- Director of Public Health (on a sessional basis from NHS Grampian)
- Consultant in Public Health Medicine (part time)
- Public Health Nurse Specialist (part time)
- Public Health Specialist
- Public Health secretary & admin support (shared with Director of Pharmacy)

The Public Health Team was redesigned in preparation for the retirement of the Director of Public Health and Planning in March 2016. As the planning role no longer sits within Public Health, the Senior Planning and Information Officer and the Information Analyst from Public Health moved to the Information Department. There was a change in the job role of the Health Improvement Manager to become a Public Health Specialist and move into the core Public Health Team; and a slight increase in the hours of the part time Consultant in Public Health Medicine. There is also now a service level agreement with NHS Grampian for sessional Director of Public Health input; along with support from the NHS Grampian Health Protection Team to provide consultant health protection cover when the part -time Shetland CPHM is not here. In addition, a more sustainable 24/7 health protection function has been developed by the creation of a Shetland based 1st on call rota (staffed by Public Health staff and senior nursing staff) supported by an Island Board 2nd on call rota (staffed by Consultants from NHS Western Isles; NHS Orkney; NHS Grampian along with the Shetland CPHM).

Funding and Resources
Table of budget and savings targets, including workforce details

Service	Number of Staff (FTE)	Expenditure	Income	Net Budget	Savings target
Core Public Health	3.2 plus DPH sessions	Budget for 2016/17 not yet finalised			Savings target for 2016/17 not yet finalised

Health Improvement Team	– see separate section

As part of the redesign, the Health Improvement Manager post within the Health Improvement Team is not being replaced. It was anticipated that this would result in sufficient savings to meet the 2016/17 target for the Public Health Directorate as a whole; however other changes to the Health Improvement Budget since April 2016 may mean that this is not longer achievable. Prior to 2016/17, the Public Health Directorate has always achieved its savings targets consistently through savings in non-pay and staff turnover, particularly within the Health Improvement Team.

Needs/Unmet needs/Drivers for change
Population health needs are changing with an increasing elderly population, and increasing demands on health and care services. Public health intervention offers the potential to change the pattern of demand, through prevention, early intervention and health improvement for which a case can be made for 'Invest to Save' in Health Improvement activity. The challenge is to do this whilst meeting departmental savings targets by reducing budgets.

There was a national review of public health in Scotland last year, and the service will need to take account of any change that results from that review (due to report 2016). There is also a North of Scotland review to strengthen public health in the north with a focus on the future resilience of public health in the Island Boards which will inform future service redesign and succession planning.

Plans for change

Description	Lead Officer	Start date/target	Expected Outcome(s) (link to National Outcomes)
Continued training and development for staff undertaking new roles and responsibilities as part of the service redesign	CPHM	April 2016-March 2017	Continued delivery of sustainable, safe and effective public health function
Reprioritisation of workload to achieve any further savings required in 2016-17 and in the future.	CPHM	April 2016-March 2017	Efficiency savings achieved whilst still working towards the following outcomes: 1 Improving health and Wellbeing 5. Reducing health Inequalities 9. Resources used effectively

Key Risks to Delivery
Increasingly we use national programme budgets to fund core staff (within Health Improvement in specifically) which brings two risks:

- around achieving savings - some programmes require performance monitoring to government which needs to show spend in programme areas, this limits our flexibility to make savings or reduce services in these programme areas;
- if national programme funding ends, unless it is replaced with new programme funding we need to reduce staffing to remain in budget. This has been managed to date through the use of short term contracts and natural staff turnover. These opportunities have now all been exhausted, so future reductions in programme budgets (such as the reduction in national bundled allocations) will result in loss of staff (and therefore a reduced service) and the

department budget will need to absorb any associated costs unless the Board reaches Board-wide agreement on supported funding. If we are faced with further restructuring in the future and staff redeployment, we will need a lead-in time to achieve savings.

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There is a risk of reduced service delivery with the already diminished staffing levels, which we will aim to minimise through reducing inefficient activity, best use of skill mix, and focus on effective practice. Any further reduction in funding will result in a reduced service, which is likely to impact specifically on locality working, work within primary care and 'face to face' working with clients unless required specifically to achieve Government targets.

Performance Targets with links to National Outcomes

Health Improvement HEAT targets are detailed in the Health Improvement section.

There are a number of targets for the national screening programmes which we consistently achieve and exceed. There are a number of targets for the national immunisation programmes where we have variable success.

Public health work supports all the the National Health and Wellbeing Outcomes to some extent but is specifically aimed at achieving the following:

Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer

Outcome 5. Health and social care services contribute to reducing health inequalities

Public Health also leads and supports delivery against a number of priorities within the Local Outcome Improvement Plan 2016-2020:

'We live longer healthier lives and people are supported to be active and independent throughout adulthood and in older age' (Increase physical activity; Improve mental health and resilience; People are the key assets in their community)

'Shetland is a safe place to live and we have strong, resilient and supportive communities' (Keeping people Safe (Domestic Abuse); Reduce the Harm caused by Alcohol)

'Shetland is the best place for children and young people to grow up' (Support children and young people to develop physical competence and confidence for the earliest age)

Contact Details

The Public Health Team is based in Upper Floor Montfield in Board HQ, Burgh Road, Lerwick ZE1 0LA. Contact via the department secretary on 01595 743340 or on email to shet-hb.publichealthshetland@nhs.net

Further Reading

Public Health Annual Report 2014/15 including Appendices on progress against the Work Programme and the Public Health Ten Year Plan: http://www.shb.scot.nhs.uk/board/strategies.asp

Appendix 1 Integrated Impact Assessment

Part 1 – Background Information

Name of Responsible Authority:	Shetland Integration Joint Board, NHS Shetland, Shetland Islands Council
Title of Plan, Programme or Strategy (PPS):	Joint Strategic Commissioning Plan 2016-19
Contact Name, Job Title, Address, Telephone Number, Email:	Simon Bokor-Ingram Director of Community Health & Social Care NHS Shetland Board Headquarters Burgh Road Lerwick Tel: 743087 e-mail: simon.bokor-ingram@nhs.net
Signature:	
Date of Opinion:	27 May 2016
Purpose of PPS: Please give a brief description of the policy, procedure, strategy, practice or service being assessed	The purpose of the plan is to show how the whole system of health and social care in Shetland is working towards improving the health and wellbeing of the people of Shetland, as set out in the national health and wellbeing outcomes.
Why PPS was written: What is the intended outcome of this policy, procedure, strategy, practice or service?	Joint strategic planning document for Integrated Joint Board (IJB) business. Statutory requirement for IJB when planning services.
Period covered by PPS: (i.e. years, months)	3 financial years: 2016-2019
Frequency of Updates (when PPS will next be updated):	Annual
Area covered by PPS (geographically and/or population):	Shetland
The degree to which the PPS sets a framework for projects and other activities, either with regard to the location, nature, size and operating conditions or by allocating resources:	Plan will set a framework for all service activities including planning change and delivery within localities and decisions on resource deployment.

The degree to which the PPS influences other PPS including those in a hierarchy:	Overarching strategic planning document for integrated health and care services, and for NHS service planning.
Summary of content:	It is a strategic commissioning plan which is structured around the client groups / services that are included within the delegated authority of the IJB. In addition it includes plans for NHS non-integrated services to provide a single Joint Strategic Commissioning Plan for health and social care in Shetland.
Objectives of PPS:	To improve national health and wellbeing outcomes for people in Shetland through the joint commissioning of services that are included within the delegated authority of the IJB, and as a single system approach to health and care service planning through NHS Shetland.
What are you trying to achieve?	Service change and redesign to improve health and wellbeing outcomes.
Is this a new or an existing policy, procedure, strategy, practice or service being assessed?	Existing strategic plan updated
Please list any existing documents which have been used to inform this Integrated Impact Assessment.	N/A
Has any consultation, involvement or research with people impacted upon by this change, in particular those from protected characteristics, informed this assessment? If yes please give details.	Yes in relation to specific client groups: Health Improvement - ongoing consultation/dialogue with people with learning difficulties, lower paid men in mainly manual type work, people of ethnic minorities, people with mental health issues. Adult Services Learning Disability and Autism - Progression of the Day Services New Build (EGRC).Stakeholder engagement has taken place in the form of regular meetings and consultation with the Eric Gray Users Group; the new Eric Gray Resource Centre Working Group which includes nominated family, carer and users. OT - Informal feedback from clients and stakeholders has helped us to define areas for improvement. Primary Care - Issues of importance to local communities have been identified through the round of Locality Planning meetings. Additional service specific information has been held by engagement with various groups eg patient satisfaction survey for ANP service at Lerwick Health Centre, General Satisfaction survey

	across all of District Nursing and Continence Service, discussions with Community Councils re health issues. Podiatry services produce annual patient satisfaction surveys for a % of caseload. Feedback from survey enables service to produce and implement action plans.
Is there a need to collect further evidence or to involve or consult people, including those from protected characteristics, on the impact of the proposed policy? (Example: if the impact on a group is not known what will you do to gather the information needed and when will you do this?)	Ongoing process of needs assessment in Health Improvement. The proposed audit of Adult Service Learning Disability and Autism service is anticipated to include engagement with people with learning disability, autism spectrum disorder, families and carers through meetings and gathered feedback. It is anticipated that this will be undertaken between April and June '16. Further engagement work will be undertaken with island Communities to explore / discuss sustainable service models for the future. The PPF will be used to discuss changes in nursing services based on the outcome of the national Review of District Nursing services. Podiatry service will continue to use both formal and informal feedback from service users to redesign and develop service provision.

Part 2 – People and Communities

	Impact (+ve / -ve / no impact / not known)	**Next Steps**
Economic	No impact/+ve – in Health Improvement all our programmes are adapted to suit individual circumstances as far as possible. For Primary Care; not known at this stage – potential limited -ve impact if reduction of employment in small communities through changes in service provision.	Discussions with partner agencies / other stakeholders as part of service reviews
Cultural	Primary Care – potentially –ve: Communities may perceive changes in service provision as having negative impact on their culture	Discussions with stakeholders as part of service reviews & engagement with communities in any major service change
Environment	No impact/+ve	

Poverty	No impact/+ve. Primary Care - Not known, may have –ve impact if changes in access to services rely on car ownership or availability of public transport. Podiatry – not known.	Engagement with communities in any major service change. Podiatry will seek service user feedback on this.
Health	No impact/+ve as services are more targeted in their approach to the provision of services to those in greatest need.	
Stakeholders	No impact/+ve. Primary care – not known.	Discussions with partner agencies / other stakeholders as part of service reviews
Equalities		
Ethnic Minority Communities (consider different ethnic groups, nationalities, language barriers)	No impact/+ve	
Gender	No impact/+ve	
Gender Reassignment (consider transgender and transsexual people. This can include issues such as privacy of data and harassment)	No impact/+ve	
Religion or Belief (consider people with different religions, beliefs or no belief)	No impact/+ve	
People with a disability (consider attitudinal, physical and social barriers)	No impact/+ve	
Age (consider across age ranges. This can include safeguarding, consent and child welfare)	No impact/+ve	
Lesbian, Gay and Bisexual	No impact/+ve	

Pregnancy and Maternity (consider working arrangements, part-time working, infant caring responsibilities)	No impact/+ve	
Other (please state)		

Part 3 - Resources

	Impact (+ve / -ve / no impact / not known)	**Next Steps**
Staff	+ve / -ve – Staff in some services will have to spread themselves more thinly with fewer resources	
Finance	+ve / no impact – we will continue to deliver within current or available resources. Some services identify that savings still need to be identified	Podiatry planning to investigate alternative methods of service delivery.
Legal	+ve / no impact	
Assets and Property	Not Known currently but potentially opportunities for sharing assets and property through integration, especially at locality levels	Consider as part of all developments being progressed

Appendix 2 Housing Contribution Statement

NHS Shetland

Shetland Islands Council

Housing Contribution Statement

March 2016

Introduction

The Housing Contribution Statement (HCS) is a statutory requirement, as set out in the Government's Housing Advice Note, 'Statutory Guidance to Integration Authorities, Health Boards and Local Authorities on their responsibilities to involve housing service in the Integration of Health and Social Care, to support the achievement of the National Health and Wellbeing Outcomes'.

The HCS sets out the contribution of housing and related services in Shetland towards helping achieve priority outcomes for health and social care. It serves as a key link between the Strategic Commissioning Plan and the Local Housing Strategy and supports improvements in aligned strategic planning and the shift to prevention.

As a local housing authority, the Council has a statutory duty and a strategic responsibility for promoting effective housing systems covering all tenures and meeting a range of needs and demands.

The Council's strategic housing plan is articulated in the Local Housing Strategy[15] which is underpinned by the robust and credible evidence from the Housing Need and Demand Assessment (HNDA)[16].

Health & Social Care Partnership

The Public Bodies (Joint Working) (Scotland) Act 2014 establishes the legal framework for integrating health and social care to ensure joined-up, seamless services. In 2015 the Integrated Joint Board (IJB) was established as a separate legal entity.

The IJB has a responsibility to produce a Strategic Plan by April 2016.

The Executive Manager – Housing is represented on the Strategic Planning Group to actively promote the housing sector's role in health and care integration. The Chief Executive of Hjaltland Housing Association is also a member of the Strategic Planning Group.

National Outcomes

The national health and wellbeing outcomes to be delivered through integration set out 9 specific outcomes. Outcome 2 is of particular relevance to setting out the housing contribution.

Outcome 2: People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

[15] http://www.shetland.gov.uk/housing/policies_housing_strategy.asp

[16] http://www.shetland.gov.uk/housing/policies_housing_need.asp

Locality Planning

Locality planning has been established and unified in Shetland at a Community Planning level. This means that strategic documents such as the LHS reflect the same 7 localities. This will allow for integration of services operationally as the local implementation plans develop.

Delegated Function

The Act sets out a range of health and social care functions, including functions under housing legislation which 'must' or 'may' be delegated to the IJB. These are contained in the Health and Social Care Integration Scheme approved in June 2015.

The housing functions that are delegated to the IJB are:

- Housing Adaptations (General Fund and Housing Revenue Account) – an adaptation is defined in housing legislation as an alteration or addition to the home to support the accommodation, welfare or employment of a disabled person or older person, and their independent living. The General Fund adaptations are carried out by Hjaltland Housing Association through their One-Stop-Shop and are for owner occupiers and tenants of private landlords. The Housing Revenue Account is where any adaptations for tenants of Council houses are funded.

Other housing functions which have a close alignment with health and social care outcomes but are not part of any delegated functions are:

- Housing support services and homelessness
- Other wider functions to address future housing supply, specialist housing provision and measures to address fuel poverty.

Local Housing Strategy

The Local Housing Strategy (2011-2016) sets out the vision for Housing in Shetland:

"to work in partnership to enable everyone in Shetland to have access to: A choice of affordable housing options across all tenures that are warm and safe, energy efficient and in keeping with the Shetland environment, of good quality and in good repair, able to meet demand and the particular needs of households in inclusive and vibrant communities."

The Local Housing Strategy sets out 5 key themes/priorities:

- Future Housing Supply
- Fuel Poverty
- Housing Support/Housing for an Ageing Population
- Homelessness
- Private Sector Housing

All of the key themes of the LHS are relevant to the HCS.

Key Issues for Shetland

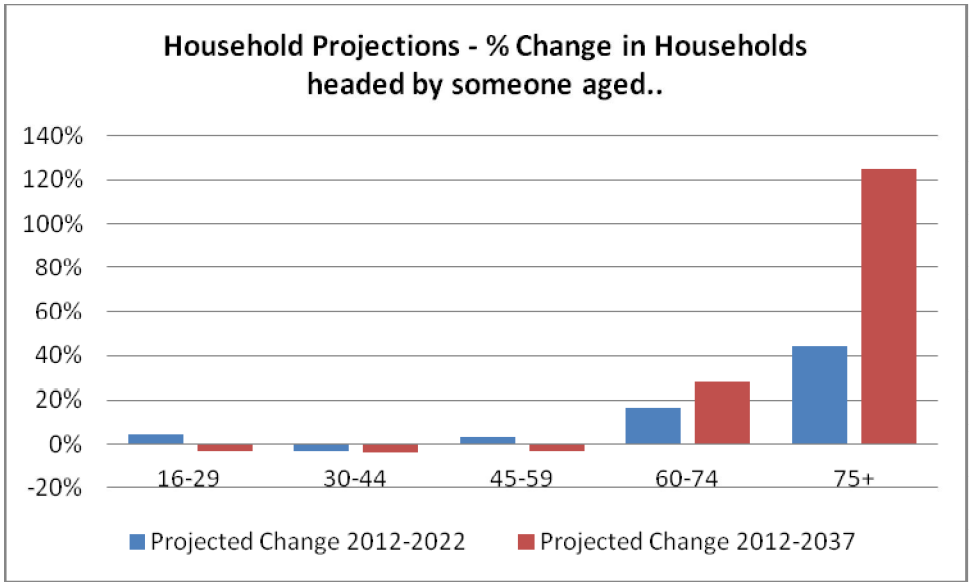
Housing Profile

Population	• 23,230[17] • 3,946 (17%) aged over 60 years
Households	• 10,201 • 9.8% increase 2004-2014 • Average household size 2.26 • 3.8% decrease 2004-2014
Household Composition	• 33% single adult households[18] • 58% small family households • 8% large family households
Dwellings	• 10,950 • 8.2% increase 2004-2014
Completions	• Annual average 94 (2010-2015) • 47% Affordable housing • 53% Private housing
Tenure	• 65% Owner occupied • 24% Social rented • 9% Private rented • 2% other
Specific needs	• 83% of the population do not consider that they are limited by a disability[19]
Specific Housing Provision	• 273 sheltered houses (social rented) • 25 extra care units (social rented) • 15 Homes for Life units (social rented in pipeline)
Adaptations	• 223 adaptations to private sector properties through Scheme of Assistance since 2011 • 70% to provide level access shower • 15% to provide ramped access • 8% both shower and ramp provision • 3% to provide WC upstairs/downstairs • 3% extension/conversion • 1% driveway/external access • Adaptations to Council properties in graph below

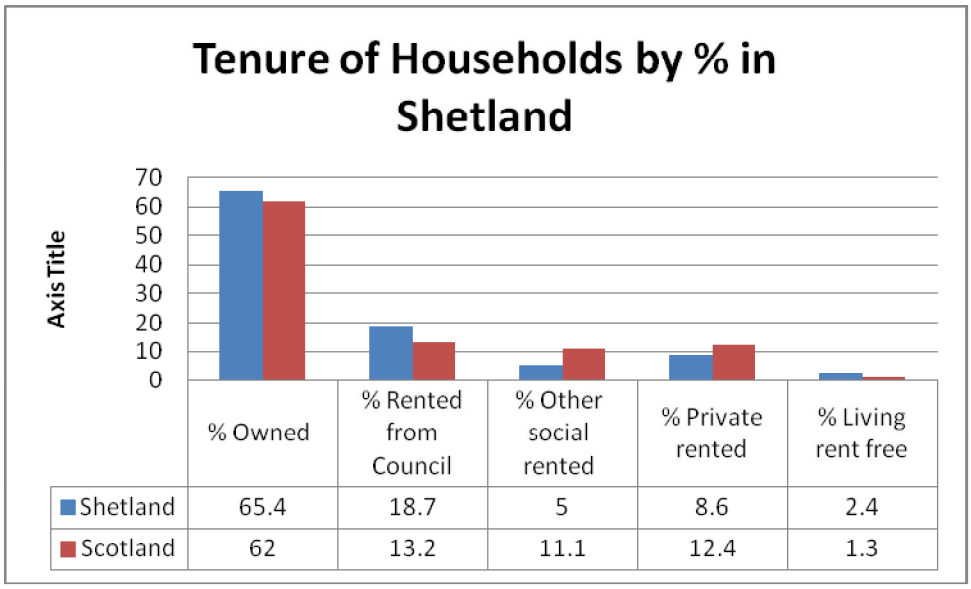
[17] GRO Scotland mid-2014

[18] National Records of Scotland 2012

[19] Census 2011



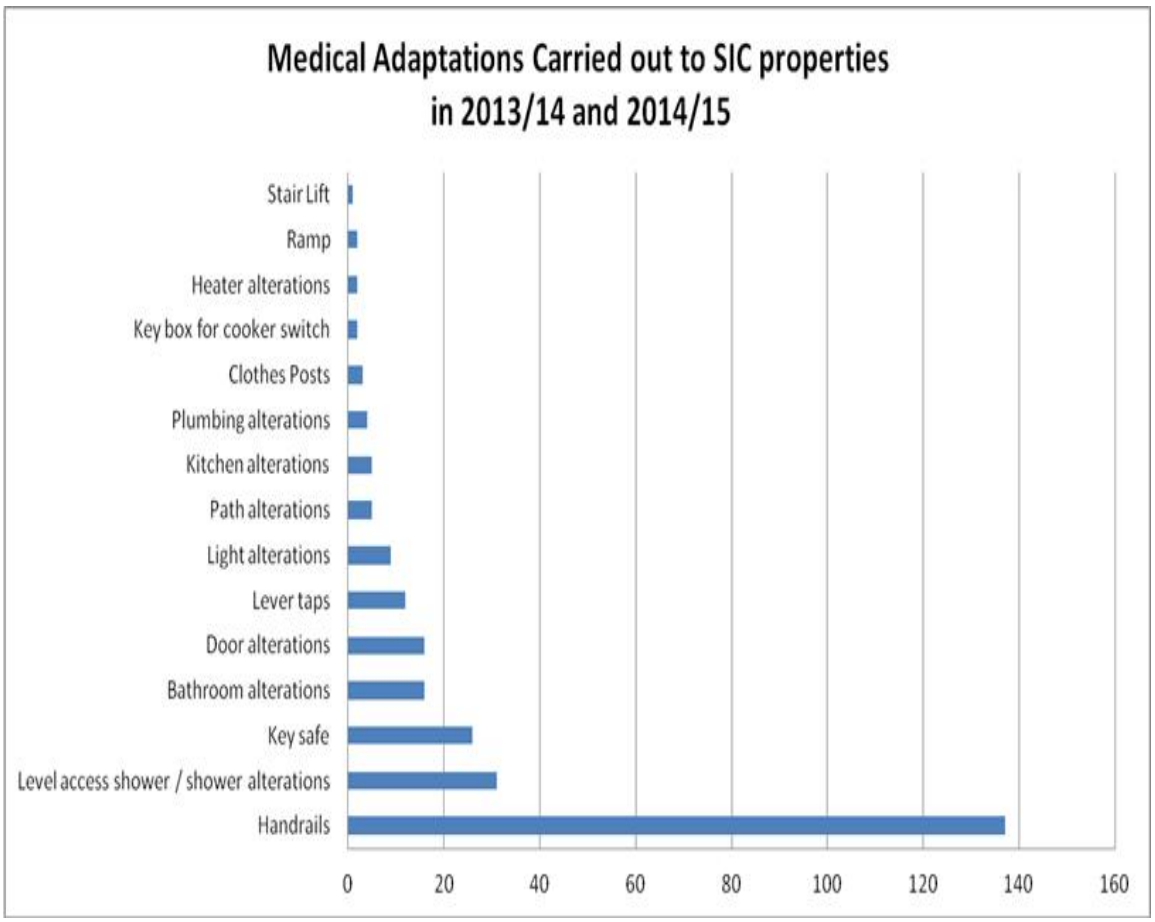
Source National Records Scotland



Source: Census 2011

Age group	Total no.	Day to day activities limited a lot	Day to day activities limited a little	Day to day activities not limited
65-74	2143	266 (12%)	505 (24%)	1372 (64%)
75-84	1178	337 (29%)	398 (34%)	443 (38%)
85 and older	456	265 (58%)	123 (27%)	68 (15%)

Source 2011 Census



Housing Contributions to Integration

- Encourage future housing supply that is the right size and in the right location across all tenures ; built to modern standards and future-proofed design, mainstreaming of barrier-free, dementia friendly design and promoting provision for the use of assistive technologies.

- Moving away from 'sheltered housing' and 'very sheltered housing' labels to accessible housing, homes with support and homes for life.

- Developing better shared assessment processes with health and care teams in localities to link with housing support plans and housing allocation process.

- Reviewing housing allocations policy to ensure that it continues to match people with housing that is suitable for their needs.

- Developing a housing options approach which would assist with longer term planning and anticipating future needs by fostering a prevention/early intervention approach to housing need. This will include developing a range of information and advice access points in partnership with a range of agencies in all localities.

- Providing a flexible and adaptable housing support service in all localities.

- Anticipate an increase in the number of adaptations required. The range and flexibility of adaptations should be reviewed to enable choices and to allow for future planning to happen as early as practicable. Timescales and priorities for adaptations to be kept under review.

- Increase the number of accessible houses in the Council's housing stock. There is a template for this from the North Isles pilot project.

- Integrating telecare and telehealth technology with provision of adaptations

- Review and develop the Handyman service for all tenures

- Recording and analysing a range of data and indicators on housing need, demand and provision to provide a robust baseline of future and anticipated needs.

Challenges

Demographic – projected rapidly ageing population will present a universal challenge in terms of delivering services to meet projected increased demands.

Financial – continued financial pressure on public sector budgets will present a number of challenges going forward. Changes to welfare benefits will impact on the housing sector.

Knowledge – there is a real need to develop better, shared baseline information about the housing and support needs of people with long term, multiple health conditions and complex needs.

Support needs – demographic change suggests that there will be a small but significant number of people who will require intensive levels of support and care. This will bring challenges in a small, mainly rural local authority where availability of specialist services may not always be locality based. There is also likely to be an increase in the demand for lower level housing support to enable people to sustain their own tenures and allow them to continue to be supported at home as far as is practicable.

Housing Stock – Shetland has an imbalance in its housing stock with a prevalence of larger sized properties whereas demand is currently for smaller properties. There are also more 'sheltered' properties in landward areas and a lack of such provision in the town. Work has been done on a pilot project to demonstrate that accessible conversions can be carried out to stock in a cost effective way.

Resources

Housing Adaptations General Fund	£355k
Housing Adaptations HRA	£104k
Total	£459k

There are no plans for any staff with responsibility for housing functions to be transferred to the health and care partnership. Close partnership working will be essential, both strategically and operationally to ensure that housing's contribution can be achieved.

The General Fund adaptations are delivered through an agreement with Hjaltland Housing Association through a 'one-stop-shop'. This model has successfully provided a range of adaptations. With projected increased demand for adaptations to enable people to stay in their own homes, resources for aids and adaptations are likely to require close monitoring and review.

Programmes of maintenance and investment in housing stock has ensured that tenants in social rented sector have homes that meet the Scottish Housing Quality Standard. Continued planned investment will focus on energy efficiency which makes a significant contribution to health inequalities.

The Council and Hjaltland Housing Association work in partnership to deliver the Strategic Housing Investment Plan which is the development of a new build programme to meet the needs and priorities identified through the LHS. The current new build plan contains provision for the proposed Homes for Life development at King Harald Street, Lerwick. HHA are also carrying out a masterplanning exercise on the large site at Staneyhill, Lerwick and there may be opportunities to include specialist provision in the planned development as that takes shape.

Monitoring and Review

This statement forms the link between the LHS and the SCP. Actions will be reviewed jointly through monitoring arrangements for both documents.

Anita M Jamieson
Executive Manager – Housing

March 2016

Appendix 2

	2016/17 Budget			2017/ 2018 Indicative Budget			2018/ 2019 Indicative Budget		
Service	**SIC**	**NHSS**	**NHSS Set Aside**	**SIC**	**NHSS**	**NHSS Set Aside**	**SIC**	**NHSS**	**NHSS Set Aside**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Mental Health	1,060	1,353	-	1,060	1,353	-	1,060	1,353	-
Substance Misuse	257	496	-	257	496	-	257	496	-
Oral Health	-	3,123	-	-	3,123	-	-	3,123	-
Pharmacy & Prescribing	-	5,714	462	-	5,714	462	-	5,714	462
Primary Care	-	4,571	-	-	4,571	-	-	4,571	-
Community Nursing	-	2,330	-	-	2,330	-	-	2,330	-
Directorate	259	94	-	259	94	-	259	94	-
Pensioners	78	-	-	78	-	-	78	-	-
Sexual Health	-	-	38	-	-	38	-	-	38
Adult Services	5,201	66	-	5,201	66	-	5,201	66	-
Adult Social Work	1,665	-	-	1,665	-	-	1,665	-	-
Community Care Resources	10,512	-	-	10,512	-	-	10,512	-	-
Criminal Justice	29	-	-	29	-	-	29	-	-
Speech & Language Therapy	-	83	-	-	83	-	-	83	-
Dietetics	-	112	-	-	112	-	-	112	-
Podiatry	-	225	-	-	225	-	-	225	-
Orthotics	-	143	-	-	143	-	-	143	-
Physiotherapy	-	603	-	-	603	-	-	603	-
Occupational Therapy	1,371	185	-	1,371	185	-	1,371	185	-

Health Improvement	-	-	310	-	-	310	-	-	310
Unscheduled Care	-	-	3,190	-	-	3,190	-	-	3,190
Renal	-	-	145	-	-	145	-	-	145
Total	**20,432**	**19,098**	**4,145**	**20,432**	**19,098**	**4,145**	**20,432**	**19,098**	**4,145**
Scottish Government Additionality Funding for Adult Social Care	512	-	-	512	-	-	512	-	-
Integrated Care Funding	-	410	-	-	410	-	-	410	-
NHSS Efficiency Target	-	-1,357	-420	-	-2,083	-569	-	-2,780	-712
Total	**20,944**	**18,151**	**3,725**	**20,944**	**17,425**	**3,576**	**20,944**	**16,728**	**3,433**
Grand Total	**42,820**			**41,945**			**41,105**		
Total 3 Year Indicative budget allocation	**125,870**								

Agenda Item

5

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	28 June 2016
Report Title:	Integrated Care Fund and use of the Additionality funding for Adult Social Care
Reference Number:	CC-43-16 F
Author / Job Title:	Simon Bokor-Ingram / Director Community Health & Social Care

Decisions / Action required:

That the IJB are asked to comment, review and endorse the proposed use of the Integrated Care Fund for 2016/17 and the use of the Additionality funding for Adult Social Care.

High Level Summary:

This report summarises how the Integrated Care Fund and the Additionality funding is proposed to be utilised in 2016/17 to support delivery of the Strategic Plan.

Corporate Priorities and Joint Working:

The planned use of the funding supports and is integral to the priorities in the Joint Strategic Plan.

Key Issues:

Shetland's Joint Strategic Plan 2016/17-19 is Shetland's plan for how services for all adults including older people will meet the outcomes of the 9 National Health and Wellbeing Outcomes. The Integrated Care Fund Plan and use of the Additionality funding is also aligned to meeting those outcomes.

Implications :	
Service Users, Patients and Communities:	The ongoing commissioning cycle and guidance on development of health and care plans, requires that customers and carers and third sector colleagues have full involvement. Engagement has taken place on an ongoing basis through a number of routes. This includes a number of planning groups involving third sector providers and service user and carer representatives and the Public Partnership Forum.
Human Resources and Organisational	Recruiting to short term posts has proven to be challenging in the past, and this had led to a delayed start for a number of

Development:	project areas. Permanent recruitment to posts with the flexibility to deploy staff to respond to service requirements will reduce the risk of not being able to take forward initiatives.
Equality, Diversity and Human Rights:	Shetlands Joint Strategic (Commissioning) Plan 2016-19 supports and promotes equalities, health and human rights.
Partnership Working:	There are well established processes in place to engage with the public; third sector and other statutory agencies. There are established forums for engagement with unions and staff. The Strategic Planning Group which reports to the IJB brings together key stakeholders and this group advises the IJB on changes to the Strategic Plan.
Legal:	Under the terms of the Public Bodies (Joint Working) (Scotland) Act 2014, the IJB is responsible for the strategic planning of the functions delegated to it by the Shetland Islands Council and NHS Shetland and for the preparation of the Strategic Plan. The Strategic Plan specifies the services to be delivered by the parties.
Finance:	The Scottish Government has made £100 million available to Health and Social Care Partnership to support delivery of improved outcomes from health and social care integration, help drive the shift towards prevention and further strengthen our approach to tackling inequalities. The Shetland IJB has been allocated £410k of this funding in 2016/17 and 2017/18. The Scottish Government settlement for 2016/17 allocated a further £250 million from the NHS to Health and Social Care Partnerships to protect and grow social care services and to deliver our shared priorities. The Shetland IJB has been allocated £1.024 million of this funding. Any slippage on planned spend against this funding will be reported to the IJB, and would carry forward to 2017/18 with a clear plan on expenditure for that year.
Assets and Property:	There are no implications for major assets and property.
Environmental:	There are no implications for major assets and property.
Risk Management:	The main risk is that of not using the Integrated Care Fund and the Additionality funding to develop and establish new service provision models. We know that traditional models of care that rely on institutional settings are resource intensive and unsustainable. Good progress has been made in recent years to shift the balance of care. We must continue to promote new ways of working and provide flexible, responsive health and care services in the community that make fullest use of new technologies. We must work in collaboration with third sector partners and communities to promote prevention, early intervention and health improvement programmes.

Policy and Delegated Authority:	Shetland's Integration Joint Board has delegated authority to determine matters relating to those services for which it has responsibility and oversight for, as set out in the Integration Scheme and the IJB Scheme of Administration [2015]. In exercising its functions the IJB must take into account the requirement to meet statutory obligations placed on the NHS and SIC, including those that pertain to delegated IJB functions.
Previously considered by:	This report has not been presented to any other formal meeting.

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	28 June 2016
Report Title:	Integrated Care Fund and use of the Additionality funding for Adult Social Care
Reference Number:	CC-43-16 F
Author / Job Title:	Simon Bokor-Ingram / Director Community Health & Social Care

1. Introduction

1.1 The purpose of this report is to inform IJB Members of how the Integrated Care Fund and the Additionality funding for adult social care is proposed to be utilised in 2016/17, to support delivery of the Strategic Plan.

1.2 The Reshaping Care for Older People Change Fund came to an end in March 2015, with the new Integrated Care Fund available to partnerships to invest in initiatives for all adults from 2015/16. The Scottish budget on 16 December announced a new £250m fund for Social Care Funding. The allocation to NHS Shetland is £1.024m for Adult Social Care outcomes. Scottish Government has issued guidelines on the use of these funds.

2. Background

2.1 The Reshaping Care Programme came to an end in March 2015. For 2015/16, an Integrated Care Fund was put in place, with centrally allocated monies that are not restricted to just older people.

2.2 The plan for use of the Integrated Care Fund this year was developed alongside the development of the Joint Strategic (Commissioning) Plan for 2016/17. The proposed spend is shown in Appendix 1.

2.3 Shetland's Joint Strategic (Commissioning) Plan 2016/17-19 is Shetland's plan for how services for all adults including older people will meet the outcomes of the 9 National Health and Wellbeing Outcomes. The Integrated Care Fund Plan is also aligned to meeting those outcomes.

2.4 Shetland's share of the £100million national resource for the Integrated Care Fund amounts to £410,000 for 2016/17, and this allocation is based on the national allocation formula for the distribution of funding to health boards (the funding comes through NHS Shetland).

2.5 Integrated Care Fund expenditure will accelerate later in the year. Any slippage on spend will be reported to the IJB, and would carry forward to 2017/18 with a clear plan on expenditure for that year. Expenditure for 2015/16 is shown in Appendix 2.

2.6 During 2015/16, funding put in place a number of key component services targeted at supporting reablement, hospital admission avoidance and early supported discharge from hospital.

2.7 The success of the initiatives put in place is measurable from particularly the indicator for delayed discharges from hospital, when over the latter part of 2015/16 there has been a marked reduction.

2.8 For 2016/17, working closely with Acute and Specialist Services, the proposed spend of the Integrated Care Fund is to continue building the capabilities to shift the balance of care further to community settings. Supporting people to maintain and enhance independence is key to enhancing people's lives, whilst maintaining service provision for those that most need it in the face of diminishing resources.

2.9 The proposed use of the Additionality funding is set out in Appendix 3. The £0.512m Scottish Government Additionality Funding for Adult Social Care represents 50% of the £1.024m received by NHS Shetland as a result of the additional £250m funding announced for health & social care partnerships which is being paid to NHS boards. This funding is to be made available to protect and grow social care services and to deliver the Scottish Government shared priorities in respect of reform for the health and social care system.

2.10 The remainder of the £1.024m additional integration funding has been recognised by Shetland Islands Council as funding to support the cost of current service delivery, i.e. to pay for cost increases and the living wage applying to all adult social care service providers. This use of the additional funding allocation is in line with the guidance from Scottish Government.

3. Conclusions

3.1 The Integrated Care Fund guidance states that it is important that the fund is used to test and drive preventative approaches to reduce future demand. The plan for Shetland has been developed to continue the approach of shifting care from hospital to the community, and to support people to remain living in their own homes wherever possible. The use of the Additionality Funding supports this shift.

Contact Details:

For further information please contact:
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E-mail: simon.bokor-ingram@nhs.net or simon.bokor-ingram@shetland.gov.uk
Telephone: 01595 743087
6 June 2016

Appendices
Appendix 1 – Integrated Care Fund 2016-17
Appendix 2 – Integrated Care Fund Expenditure 2015/16
Appendix 3 – Proposed use of Additionality Funding

Background documents
Joint Strategic (Commissioning) Plan for 2016/17
http://www.shetland.gov.uk/Health_Social_Care_Integration/StrategicPlan.asp

2016/17 Integrated Care Fund

Product	2016/17 Integrated Care Fund Allocation	Comments	Detail	Aligning to National Health and Wellbeing Outcomes
Proactive Care and Support				
- Intermediate Care Service	443,247	Estimated cost for a full year = £476,970; slippage on recruitment so have part funded.	Staffing costs 13.18FTE : includes 1FTE Team Leader; 7FTE Healthcare Support Workers; 2.67FTE Physiotherapist; 1.11FTE Occupational Therapist; 1.4FTE Patient Flow and 5% recharge for Management costs. Operational costs include training, transport, recruitment and running costs for reablement property.	People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonbale practicable, independantly and at home or in a homely setting in their community.
- Medical input and clinical expertise to support community initiatives including Intermediate Care and Anticipatory Care Planning.	30,000	Will fund consultant time that focuses on community activities.	Funds consultant programmed activities= time.	
- Identifying unmet need for long-term neurological conditions using a neurophysiotherapist to work with primary care and voluntary sector.	16,906	1 year appointment started in Aug'15. Balance of funding carried into 2016/17 to meet the 1 year contract.	1FTE Physio for 4.5 months - remainder of 1 year contract.	People are able to look after and improve their own health and wellbeing and live in good health for longer.
	490,153			
Preventative and Anticipatory Care				
- Accelerated rate of anticipatory care plan development across primary care, housing and social care.	15,627	Balance of funding from 2015/16 carried forward into 2016/17 for ongoing ACP development	Funds backfill for focusing on ACP developments.	People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonbale practicable, independantly and at home or in a homely setting in their community.
- Provision of hearing impairment training to community staff so they can better support clients.	16,000	Provision of hearing impairment training and support to community care staff.	Increase of 0.4FTE in Audiology Support Assistant hours to full time for 12 months and additional resources to provide training.	Public services contribute to reducing health inequalities.
	31,627			
Supportive Enablers				
- Third sector provided Independent Living Support at Home across seven localities to provide ongoing reablement and social engagement.	30,000	Require balance of 2015/16 contract funding £12,408 to be carried into 2016/17 to cover remainder of 1 yr contract. 2016/17 allocation to cover to end of financial year.	12 months at current RVS contract price = £29,778.	People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonbale practicable, independantly and at home or in a homely setting in their community.
- Contingency to fund priorities that emerge from Strategic Planning process.	30,000	Funding that IJB can direct to particular area/s	Uncommitted resource that can be directed by the IJB to a particular area where there is need identified.	Resources are used effectively and efficiently.
	60,000			
TOTAL : Integrated Care Fund 2016/17 Planned Spend	**581,780**			
Less Total Integrated Care Fund Allocation for 2016/17	**581,780**			
Balance of 2016/17 Funding Remaining	**0**			

Note:

2015/16 Integrated Care Fund = £410,000 - balance of £171,780 to be carried forward into 2016'17

2016/17 Integrated Care Fund = £410,000

TOTAL 2016/17 Allocation = £581,780

2015/16 Integrated Care Fund

Product	2015/16 Integrated Care Fund Allocation	Out-turn Expenditure to Year End	Balance Remaining	Comments
Proactive Care and Support				
- Intermediate Care Service including hospital discharge liaison.	285,000	158,346.00	126,654.00	Balance of funding required to be carried into 2016/17 to meet ongoing Intermediate Care Service costs.
- Medical input and clinical expertise to support community initiatives including Intermediate Care and Anticipatory Care Planning.	30,000	30,000.00	0.00	
- Identifying unmet need for long-term neurological conditions using a neurophysiotherapist to work with primary care and voluntary sector.	35,000	18,130.00	16,870.00	1 year appointment started in Aug'15. Shall require balance of funding to be carried into 2016/17 to meet the 1 year contract.
	350,000	**206,476.00**	**143,524.00**	
Preventative and Anticipatory Care				
- Accelerated rate of anticipatory care plan development across primary care, housing and social care.	30,000	14,373.00	15,627.00	Balance of funding to be carried forward into 2016/17 for ongoing ACP development
	30,000	**14,373.00**	**15,627.00**	
Supportive Enablers				
- Third sector provided Independent Living Support at Home across seven localities to provide ongoing reablement and social engagement.	30,000	17,370.50	12,629.50	Contract awarded to RVS for 12 mths at £29,778, due to delay in start date the contract shall carry forward into 2016/17. Require balance of £12,408 to be carried into 2016/17 to cover remainder of contract.
	30,000	**17,370.50**	**12,629.50**	
TOTAL : Integrated Care Fund 2015/16	**410,000**	**238,219.50**	**171,780.50**	**Balance to be carried forward into 2016/17**

Note:

2015/16 Integrated Care Fund = £410,000

2016/17 Additionality Funding Held by IJB for Adult Social Care

Proposed Draw on Additionality Funding	2016/17	Comments	Detail	Aligning to National Health and Wellbeing Outcomes
Social Work - hospital discharge liaison	78,330	Specifically to focus expediting timely hospital patient discharges, co-ordinating all agencies to ensure that rehabilitation is prioritised.	1FTE Social Worker at K2 plus mileage/phone allowance; 1FTE Admin at G2.	People, including those with disablities or long term conditions or who are frail are able to live, as far as reasonable practicable, independantly and at home or in a homely setting in their community.
Reablement Programme Support to Care Centres	86,100	To focus primarily on Montfield Support Services and develop the rehabilitation model further.	1FTE Physio at Band 6; 1FTE OT at Band 6 plus recruitment and mileage costs.	
Self-Directed Support Packages	347,570	Increase in uptake of Option 1 of Self Directed Support (full estimated cost at 31/05/16 is £354,485).	Costing based on current self-directed support packages at 31/05/16 for the remainder of 2016/17; takes into account increased hourly direct payment rates approved by Council for 2016/17. Increase in uptake of packages - October 2015 = 30 packages. June 2016= 37 packages.	Public services, particularly Health and Social Care services, are centered on helping to maintain or improve the quality of life of people who use them.
TOTAL : 2016/17 Additionality Funding Proposals Received	**512,000**			
2016/17 Additionality Funding	**512,000**			
Balance Remaining	**0**			

Note:

2016/17 Scottish Government announced additional £250M for Adult Social Care Outcomes - indicative allocation for NHS Shetland was £1.024M.
Following Scottish Government guidelines for use of this funding - £512,000 was allocated to support the cost of current service delivery with the remaining £512,000 held by the IJB for the delivery of additional Adult Social Care services and outcomes in order to address the rising demand for services from an ageing population.

Agenda Item

6

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board Shetland NHS Board	28 June 2016 23 August 2016
Report Title:	Draft Oral Health Strategy	
Reference Number:	CC-48-16 F	
Author / Job Title:	Raymond Cross, CADO/Clinical Director of Dental Service	

Decisions / Action required:

To APPROVE the Draft Oral Health Strategy;

1. **The Integration Joint Board (IJB) are asked to**:
   a) Approve Draft Oral Health Strategy, and recommend it is considered for approval by NHS Shetland
   b) Instruct that a detailed Action Plan will be presented to the IJB in six months time

2. **Shetland NHS Board are asked to**:
   a) Approve the Draft Oral Health Strategy having taken into account the key issues identified in this report and the recommendations of the IJB

High Level Summary:

The draft Oral Health Strategy has been developed to give a direction of travel for oral health care in Shetland and a high level implementation plan is included in Section 13 of the Strategy. It should be noted that at the same time as the Strategy will be implemented, it is anticipated that national guidance on a new Scottish GDP contract will be released and this guidance will need to be incorporated into the detailed implementation plan once received.

Corporate Priorities and Joint Working:

The draft Oral Health Strategy was developed through a literature review, policy analysis, data gathering on population oral health and demography, the local workforce and activity in primary dental care, and engagement with staff and the public partners.

Key Issues:

- There has been a complete lack of independent NHS dental practices in Shetland for the past five years until very recently, despite a Scottish Government Dental Access Initiative scheme being in place to encourage new NHS practices to open.
- This shortfall has been filled in part by the Public Dental Service (PDS) expanding its remit into registering and seeing almost the whole Shetland population.
- Only when there are significant levels of primary dental care provided through the independent NHS practice sector, can the PDS begin to concentrate more on its intended remits

Implications :	
Service Users, Patients and Communities:	Successful implementation of the draft Oral Health Strategy will improve patient access to oral health services and contribute to improved outcomes for service users, and the community.
Human Resources and Organisational Development:	Shetland's Public Dental Service will enter a period of redesign, including continuing to attract sufficient alternative primary dental care providers for the general population. Consultation and engagement with staff and other stakeholders will remain vital for the maintenance of staff welfare and morale.
Equality, Diversity and Human Rights:	The IJB are required to ensure that systems are monitored and assessed for any implications in this regard. The objectives of the draft Oral Health Strategy support and promote equalities, health and human rights.
Legal:	The conditions of General Dental Practitioner contracts are legally binding and it is for NHS Shetland to monitor adherence to these.
Finance:	Any costs associated with the implementation of the Oral Health Strategy will be met from designated SG funding and within existing budgets of the Community Health and Social Care Directorate.
Assets and Property:	The draft Strategy itself has no immediate impact on existing property, although business developments of further independent NHS dental practices may affect these in the future.
Environmental:	There are no environmental issues arising from this report.
Risk Management:	Embedding a culture of continuous improvement and customer focus are key aspects to meeting the aspirations of the IJB, and ensuring delivery of the Strategic Plan. Failure to promote and embed a continuous improvement culture within local NHS oral health care would increase the risk of NHS Shetland working inefficiently and of the IJB being subject to negative external scrutiny.

Policy and Delegated Authority:	Shetland's Integration Joint Board has delegated authority to determine matters relating to those services for which it has responsibly and oversight for, as set out in the Integration Scheme and the IJB Scheme of Administration [2015]. In exercising its functions the IJB must take into account the requirement to meet statutory obligations placed on the NHS and SIC, including those that pertain to delegated IJB functions. This particular report is presented to the IJB in terms of its responsibility for the planning of integrated services, and for overseeing implementation of the Oral Health Strategy in Shetland. The Chief Officer is responsible for the operational

	management of integrated services
Previously considered by:	This report has not been presented to any formal meeting previously.

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	28 June 2016
Report Title:	Draft Oral Health Strategy
Reference Number:	CC-48-16 F
Author / Job Title:	Raymond Cross / CADO/Clinical Director of Dental Service

1. Introduction

1.1 This paper provides the IJB with the Draft Oral Health Strategy for Shetland ("The Strategy"), including a high level implementation plan under Section 13.

1.2 It is proposed that the IJB agree the Strategy and agree that a detailed Action Plan will be presented on a six monthly basis.

2. Background

2.1 The Strategy has been developed during 2015/16 and this is the first time it has been presented to the IJB. The Strategy was developed through a literature review, policy analysis, data gathering on population health, the local workforce and activity in primary care, and engagement with staff and public partners. It sets out a description of Oral Health for All in six 'vision' statements, the present situation of oral health care services in Shetland, a comparison to those in Scotland as a whole, and sets out a direction of travel towards oral health for all.

3. Current Situation

3.1 There have been ongoing issues for Shetland due to the lack of any local independent NHS dental practices for some years, which have forced the Public Dental Service (PDS) to reduce its focus on treating people with special needs in order to meet this shortfall. Even with an NHS dental practice opening in Lerwick in 2016 there remains a huge shortfall in available primary dental care capacity that needs addressing before the PDS can really re-focus its efforts into more specialised areas of oral health provision.

3.2 There are specific challenges to independent NHS practices opening in Shetland, and especially to the less populated areas that require small scale dental services, which are likely to result in the PDS needing to continue to provide primary care dentistry to the whole population of the remotest communities whilst independent practices focus solely on the relatively more populated locations. This has implications for the cost efficiency of PDS services covering large geographical areas with the associated travel and transport implications.

3.3 A revised contract for General Dental Practitioners is expected to be presented during 2016-17, which will change the arrangements for treating children within the independent NHS dental practices. It is not yet possible to anticipate its potential effect on the provision of dental services in Shetland.

3.4 Further developments in the provision of independent NHS practices are anticipated within the next year which may help speed the Action Plan development.

4. Conclusion

4.1 This Strategy has been prepared in collaboration with staff of the Public Dental Service and Directorate of Community Health & Social Care.

4.2 An Action Plan will be developed to reflect the current and evolving provision of primary care dental services in Shetland.

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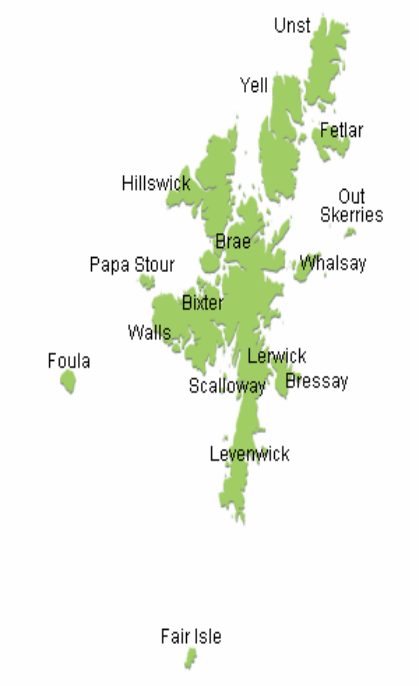
9th June 2016

Appendices

Appendix 1 – Draft Oral Health Strategy for Shetland

Oral Health for All -

An Oral Health Strategy for Shetland 2016 - 2020



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NHS SHETLAND DOCUMENT DEVELOPMENT COVERSHEET*

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Author	**Raymond Cross**	
Executive Lead	**Simon Bokor Ingram**	

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ACF	
Child Health Forum	

DATE	VERSION	GROUP	REASON	OUTCOME
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Examples of reasons for presenting to the group	Examples of outcomes following meeting
• Professional input required re: content (PI)	• Significant changes to content required – refer to Executive Lead for guidance (SC)
• Professional opinion on content (PO)	• To amend content & re-submit to group (AC&R)
• General comments/suggestions (C/S)	• For minor revisions (e.g. format/layout) – no need to re-submit to group (MR)
• For information only (FIO)	• Recommend proceeding to next stage (PRO)
• For proofing/formatting (PF)	• For upload to Intranet (INT)

Please record details of any changes made to the document in the table below

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1.2016 to 6.2016	General editing.
1.2016 to 6.2016	Development of final Section on 'Shaping Oral Health Service in Shetland for the future' (i.e high-level priorities for implementation) whilst awaiting announcement of imminent SG Oral Health Plan.

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Executive Summary

This Strategy describes the vision of 'Oral Health for All' people in Shetland, and actions that can be taken locally towards achieving this vision. The present delivery of oral health care in Shetland is described, and compared with the Scottish Government's expected pattern.

Dental decay (dental caries) and gum disease (gingivitis and periodontal disease) are probably the commonest health problems in the world, and both are largely preventable, provided simple diet and oral hygiene measures are followed. This strategy focuses on a preventative approach towards these and other oral health issues, whilst also recognising the necessity of supporting and treating people who have established disease.

The oral health needs of the population vary according to their age group. The oral health of children in Shetland is among the best in Scotland, showing the effectiveness of preventive dentistry in helping people avoid caries and periodontal disease through the Childsmile programme. Prevention aims to meet the vision of 'Oral Health for All' children, and this will extend to adults too, as the decay-free children grow into adulthood. Despite this, there remains a social inequality in disease prevalence that still needs addressing.

The oral health of older people in the local population, though, is not so good overall. Many older people have numerous heavily restored teeth, and/or dentures, requiring frequent and expensive maintenance care to help them preserve their slowly failing dentition. They are also more likely to have established periodontal disease, needing regular professional input to help slow its progress. The number of older people in the local population is rising, more people are retaining their own teeth for longer, and the percentage of older people is higher in more remote areas than it is in Lerwick. For each of these reasons the provision of oral health care for older people will be a continuing and growing challenge for the decade to come. Although the aim of 'Oral health for All' older people is still a distant prospect, this Strategy targets the essential direction of travel to be pursued.

The majority of oral health care in Scotland is expected to be provided by independent dental practices each contracting to provide NHS care. Health Boards are expected to provide a Public Dental Service for the care of people who, for whatever reason, are not able to be seen within the independent NHS dental practices, and to provide consultant-led services for people with complex conditions. Nationally, Managed Clinical Networks are being established to help reduce the primary care/secondary care divide, and facilitate the clinical oversight of clinicians irrespective of their work location.

Because Shetland has had a long-standing shortage of independent NHS dental practice capacity, and none at all between 2011 and early 2016, there has been a shortfall in primary dental care provision which the Public Dental Service has been covering under its safety net remit. Once additional independent NHS dental practices are attracted to open in Shetland and increase the overall capacity for primary dental care, the Public Dental Service will be expected to re-focus towards targeted dental care for people with Special needs, more locally available specialist care, and more oral health promotion, whilst continuing to provide routine dental services in areas where the remote and rural geography of Shetland makes it unlikely that independent NHS practices will ever choose to open.

1.0 Introduction

Since the publication of the NHS Shetland Dental Strategy 2012-15 there have been a number of significant developments at National and local levels affecting the provision and oversight of oral health care. The aim of this Oral Health Strategy is to renew the vision for oral health in Shetland, in the light of these and other developments, and provide a clear road-map to follow for the next five years to improve the oral health of the population.

- In 2013 Scottish Government established the Public Dental Service (PDS) with a remit including both clinical and public health elements, replacing the previous Community Dental Service and Salaried General Dental Service with a unified salaried dental service.
- In 2015 the Public Dental Service was included in the Community Health and Social Care Integration Joint Board. This has changed the landscape with regard to the provision and oversight of oral health care services.
- In addition, the Government's Programme for Scotland 2015-16, includes an announcement of changes to how NHS dentistry is to be regulated and monitored in the future. "...We will also improve the oral health of people in Scotland with a clear focus on reducing inequalities. By further reducing dental decay we will address the most common reason for admitting a child to hospital. We will transform the outdated and complex dental system to meet the needs of younger people who need to maintain a preventive focus whilst ensuring that the treatment needs of the older population are met. An e-Dental programme will improve the assurance, governance, efficiency and information on quality of services."

A new national Dental Action Plan is expected to be issued by the Chief Dental Officer following the Scottish assembly elections in 2016.

2.0 The Vision of Oral Health for All the People of Shetland

Recognising that each individual is ultimately responsible for their own oral health, and that different age groups in the population have slightly different needs, the focus of this Strategy can be summarised in six specific Vision statements.

Vision statements 1 and 2 refer to individual oral health, statements 3 and 4 refer to the public health aspects of oral health, and statements 5 and 6 refer to local dental services.

1. All children in Shetland can develop and shed their deciduous teeth with no significant intervention from NHS dental services, and develop their adult dentition free from the two main dental diseases - dental decay (caries) and gum disease.
2. All adults can maintain a healthy natural dentition through to later life with minimal need for artificial replacement.

3. All age groups of the local population know the causes of common oral health diseases and the measures that can be taken daily to prevent their onset.

4. Effective mechanisms are in place to overcome inequalities in oral health in the local population, with enhanced support and prioritisation being given to disadvantaged individuals and communities.

5. All the population can access high quality, affordable, safe, and effective NHS oral health care services.

6. The vast majority of people requiring specialist oral health care can receive this in Shetland.

3.0 Background Context

The Scottish Government vision for health care is "that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting." This is the basis for the National NHS Quality Strategy for care which is person-centred, safe and effective. This document particularly focuses on hospital and community services, but its themes are equally applicable to oral health care.

Shetland Health Board has its own 2020 Health and Care vision document, which states, "In 2020… Shetland continues to deliver high quality, local health and care services, which have developed to ensure they are suited to the needs of the population in 2020. We make best use of our community strength, community spirit and involvement, which has helped to shape our services as well as our way of life. People feel responsible towards each other within their own community. Self-help includes making healthy lifestyle choices and people using their knowledge and own capacity to look after themselves and each other....." This, and several other statements in a similar vein, set the local context for health care provision in Shetland.

A further refinement of the Shetland 2020 Vision document was published in 2011 as the **Clinical Strategy for Shetland,** which was renewed and updated in December 2014. This document expands the strap line, "Creating Sustainability, Ensuring Resilience, Securing the Future" and identifies the following principles for longer-term service planning as:

- To sustain core services and maintain viability
- To enhance the future retention and recruitment of staff
- To enhance training and development opportunities
- To develop partnership working with other agencies
- To strengthen and develop health promotion and education
- To enhance primary care services
- To provide care in the most appropriate setting
- To maximise the benefits of new technology
- To improve the environment of healthcare facilities

The Clinical Strategy for Shetland sets the local context for this Oral Health Strategy, which aims to apply these objectives to the oral health of the population.

Following its Review of Primary Care Dental Services in Scotland (2006), the Scottish Government established the Public Dental Service (PDS) in 2013, replacing the Community Dental Service (CDS) and the Salaried General Dental Service (SGDS) with a

single, managed primary care dental service for Scotland. SGDS services had originally been introduced as a temporary measure to cover a shortfall in the capacity of independent NHS practices in remote and rural areas, but the Scottish Dental Access Initiative (SDAI) has now increased the capacity in all but a few geographical areas. Shetland remains the only Health Board area where there is no restriction on where SDAI-supported practices can be located.

The Scottish Government's determination to integrate Health and Social Care provision came to fruition in 2015 when, in Shetland, the Integration Joint Board became responsible for the services within the Directorate of Community Health and Social Care, including the Public Dental Service. The Public Bodies (Joint Working) (Scotland) Act 2014 Clinical Governance Framework provides a list of nine **National Health and Wellbeing Outcomes** that are applicable to all health and social care services that come under the oversight of the Integration Joint Boards.

These are:

Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer.

Outcome 2: People including those with disabilities, or long term conditions, or who are frail, are able to live, as far as reasonable practicable, independently and at home or in a homely setting in their community.

Outcome 3: People who use health and social care services have positive experiences of those services, and have their dignity respected.

Outcome 4: Health and Social Care Services are centred on helping to maintain or improve the quality of life of people who use those services.

Outcome 5: Health and social care services contribute to reducing health inequalities.

Outcome 6: People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.

Outcome 7: People using health and social care services are safe from harm.

Outcome 8: People who work in health and social care services feel engaged with the work they do are supported to continuously improve the information, support, care and treatment they provide.

Outcome 9: Resources are used effectively in the provision of health and social care services.

4.0 Demography

4.1 Demography

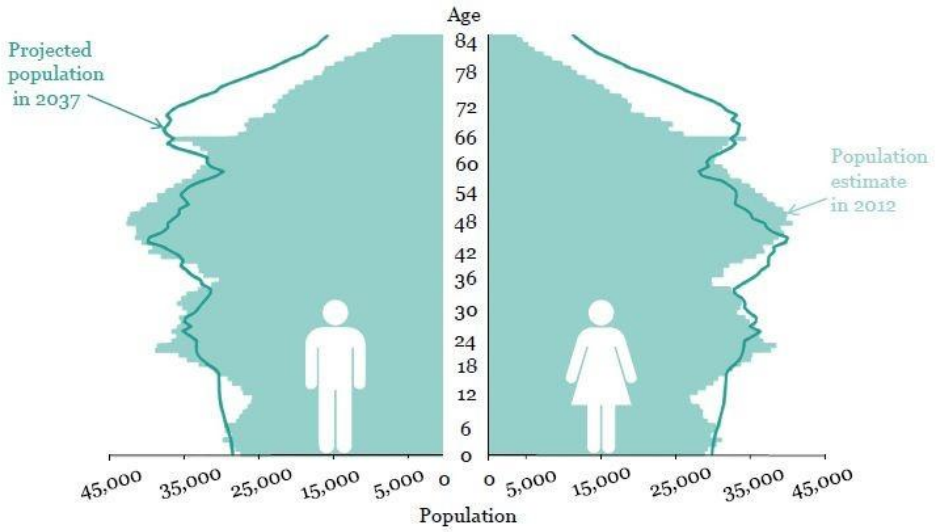
This Strategy covers the oral health of the entire resident population of Shetland of around 23,200, (ONS 2013 mid-year estimate.) It also includes the urgent needs of visitors and temporary workers to the islands in view of NHS Shetland's responsibility to provide for their urgent oral health needs on an occasional basis.

	Pre-school	School age	Young people	Working age adults		Older people			All
Age	0 - 4	5 - 14	15 - 24	25 - 44	45 - 64	65 - 74	75 - 84	85+	Total
2011 Census	1389 (6%)	2776 (12%)	2746 (12%)	5859 (25%)	6620 (29%)	2143 (9%)	1178 (5%)	456 (2%)	23167 (100%)
2014 GP Regis-trations	1303 (6%)	2592 (11%)	2615 (11%)	5659 (25%)	6533 (29%)	2454 (11%)	1256 (5%)	474 (2%)	22886 (100%)

Table 1 Breakdown of the Shetland population by age, and by two different collection methods

It is predicted that the demography of Shetland will change during the 5 year period of this Strategy. The overall population is expected to increase slowly, despite the working-age population shrinking and the birth rate remaining steady, due to an increasing number of older people. These demographic changes are roughly in line with the Scottish population projections illustrated in Figure 1, and will have implications on how, what and where oral health care is provided locally.

Figure 1



Population projections based on 2012 suggest that the population of Scotland may rise to 5.78 million by 2037 and that the population could age significantly, with the number of people aged 65 and over increasing by 59 per cent, from 0.93 million to 1.47 million.

Source: Scotland's Population Infograph Report 2014 National Records of Scotland

4.2 Ethnicity

According to the 2011 census, 94.8% of the resident Shetland population described themselves as of White British origin, and the other 5.2% were either from a wide range of black and minority ethnic backgrounds, or were 'white non-British.' These differences are of little significance to oral health, or to oral healthcare unless there is a significant language barrier between clinician and patient.

4.3 Geography

Shetland comprises over 100 islands, of which 15 are inhabited, stretching 100 miles from Fair Isle in the south to Unst in the north. It is said that nowhere is more than three miles from the sea. The population of the main town Lerwick is around 7000. Around 50% of the population live in widely scattered villages in a sparsely populated, rugged countryside. The geography thus presents challenges to service planning, to ensure equity in service access and provision.

There is a geographical variation in the age profiles of different communities across Shetland which can be demonstrated using GP practice population data. The percentage of older people is lower in Scalloway and Brae (around 15%) than elsewhere, and higher in the island practices of Unst (29.4%), Yell (24.5%) and Whalsay 22.8%. These differences have implications for service provision in these areas.

Practice	Total	Age under 65	65-74	75-84	85 and over	% aged over 65
Lerwick	9005	7383	930	497	195	18.0%
Scalloway	3296	2815	275	144	62	14.6%
Levenwick	2685	2188	296	156	45	18.5%
Brae	2486	2107	248	97	34	15.2%
Whalsay	1144	881	149	84	30	22.9%
Bixter	1143	935	123	68	17	18.2%
Yell	1073	810	151	91	21	24.5%
Hillswick	754	614	80	37	23	18.6%
Walls	722	561	94	41	26	22.3%
Unst	578	408	108	41	21	29.4%

Source : Local GP data

Table 2: Shetland GP practice populations by age group (April 2014)

5.0 Dental diseases - Barriers to Oral Health

"Oral health is a standard of health of the oral and related tissues which enable an individual to eat, speak and socialise without active disease, discomfort or embarrassment and which contribute to well-being." (UK Department of Health 1994). This definition recognises that teeth are important for biting, chewing, speaking and smiling, and that they have an important part to play in maintaining good nutrition and in socialising.

In addition to the two main diseases of the oral cavity, tooth decay and gum disease, this Strategy includes a range of other oral conditions that need separate mention. Each has its own aetiology, although there are some common risk factors between them.

Vision 3 focuses on the local population having knowledge of the causes of oral health diseases so that that they can take their personal responsibility for their oral health and oral health care.

Vision 3:
All age groups of the local population know the causes of common oral health diseases and the measures that can be taken daily to prevent their onset.

5.1 Dental Decay

The local effect of dietary sugars has a fundamental role in the disease, and people at high risk of contracting dental decay have a frequent sugar intake. Bacteria resident in the mouth use the ingested sugars to produce acid which demineralises enamel and dentine, destroying its structure. There are other overlapping factors which also increase the risk of contracting the disease, such as high levels of dental plaque, low levels of manual dexterity, etc. Oral health promotion messages focus on diet modification, more effective oral hygiene, and the use of topical fluorides (that help reduce demineralisation.) There is also a wide range of additional advice for people with very specific risk factors.

In March 2014 the Scottish Intercollegiate Guidelines Network published a National clinical guideline 'Dental interventions to prevent caries in children.' This evaluated a range of interventions, and provided a brief list of recommendations:

- Oral health promotion interventions should facilitate daily tooth-brushing with fluoride toothpaste.
- Following risk assessment, children and young people up to the age of 18 years who are at standard risk of developing dental caries should be advised to use toothpastes in the range 1,000 to 1,500ppmF. [parts per million of fluoride].
- Following risk assessment, children aged from 10 to 16 years who are at increased risk of developing dental caries should be advised to use toothpastes at a concentration of 2,800 ppmF.
- Tooth-brushing with fluoride toothpaste should take place at least twice daily.
- Fluoride varnish should be applied to teeth of all children at least twice yearly.
- Resin-based fissure sealants should be applied to the permanent molars of all children as soon after eruption as possible.

The document also lists factors that should be considered when assessing the risk of children developing dental caries. Many of these are issues common to the whole family, so siblings will generally have equal levels of risk. These include:

- Clinical evidence of previous disease – this is the highest indicator of the present risk.
- Dietary habits, especially the frequency of sugary food and drink consumption.
- Social history, especially socioeconomic status. Caries is most prevalent in children from low socio-economic status families. Infants living in areas of high deprivation have significantly more caries than those from more affluent areas.
- The usage of fluoride.
- Plaque control through tooth-brushing etc
- Saliva. Saliva fulfils a major protective role against dental caries. A small proportion of children may have reduced salivary flow, usually as a consequence of their medical history and related drug therapy, and are at high risk of dental caries.

- Medical history. Apart from the medical condition itself, children taking regular oral medication are at high risk unless the medication is in a sugar-free formulation.

5.2 Periodontal Disease

Periodontal diseases comprise of a group of related conditions, both acute and chronic, characterised by inflammation of the periodontal tissues in response to the presence of dental plaque. Dental plaque is the biofilm of bacteria that inhabit the mouth and particularly stick to the teeth. Periodontal disease is largely preventable with good oral hygiene, although there are many conditions that increase the likelihood of a patient developing the disease. The milder form, gingivitis, is inflammation limited to the gum tissue immediately adjacent to the teeth, and is reversible. It is usually recognised by the gum margins bleeding on brushing. Periodontitis is more extensive, affecting the deeper tissues that hold the teeth in place. If allowed to continue the teeth may drift out of alignment, become increasingly mobile, and are eventually extracted or exfoliate by them.

Smoking and diabetes are significant factors for periodontitis.

Patients who smoke do not respond to periodontal treatment as well as non-smokers, and are also more likely to lose teeth. Smoking is thought to reduce the blood flow to the gums, (thereby suppressing the signs of gingivitis), and impairs wound healing.

Patients with diabetes also have an increased risk of developing periodontal diseases. Poorly controlled diabetes enhances the signs and symptoms of gingivitis and periodontitis and has an adverse effect on wound healing, making the treatment of the patient more difficult. There is some evidence that the successful treatment of periodontal disease can improve glycaemic control.

There is a developing body of evidence indicating an association between periodontitis and cardiovascular disease. This may be due to shared risk factors. Results of large scale prospective clinical trials to determine whether treating periodontal disease can improve cardiovascular outcomes are not yet available.

Other factors that may predispose a patient to developing periodontitis are stress, diet, obesity, osteoporosis and rheumatoid arthritis, but currently the scientific evidence is relatively unclear.

Certain drugs used for treating hypertension, epilepsy and tissue rejection can cause gingival enlargement, as may the hormonal changes of adolescence and pregnancy.

Localised risk factors such as the presence of calculus (tartar), mal-positioned teeth, overhanging dental restorations and wearing partial dentures also increase the risk of periodontal disease.

Prevention of periodontal disease is the daily task of each person, through effective brushing to remove plaque from the teeth around the gum margins. The role of the dental professional is to inform and encourage people to maintain good oral health, to identify and treat oral disease when it occurs, help identify risk factors, and to contribute positively to the health and well-being of the population they see.

5.3 Oral Cancer

According to figures from Cancer Research UK, 6767 people were diagnosed with oral cancer in the UK in 2011. In Scotland the age-standardised incidence rate was 11.8 cases per 100,000 population, considerably higher than the 9.0 rate for the UK as a whole. It can therefore be expected that 2-3 Shetland people per year will be diagnosed with oral carcinoma. The geographical variation in oral cancer incidence across the UK largely reflects the prevalence of the two most well-established oral cancer risk factors – excessive alcohol consumption and smoking. It is estimated that up to 90% of all cases of oral cancer are caused by these two habits. Thus the vision for better oral health includes building links with health promotion activities for smoking and alcohol related diseases.

5.4 Dental Trauma

Accidental damage to the teeth is common, and can have life-long consequences for people affected. It also has considerable implications for dental services, as repair and/or replacement will be costly over a lifetime. Preventing damage, by such means as wearing mouth-guards whilst participating in contact sports, is advisable, and the UK governing bodies of some sports now make their use mandatory. The compulsory use of seat belts in vehicles has been effective in reducing the incidence of dental trauma, as well as head injury.

5.5 Medical Conditions and oral pathology

There are many systemic diseases that may exhibit oral manifestations, of which the dental professional should be aware. Patients with these, and other oral conditions, may need to be diagnosed and treated by specialists with additional knowledge and expertise above the level expected of a general dental practitioner.

5.6 Orthodontic Conditions

Orthodontics is the branch of dentistry that deals with the diagnosis, prevention and correction of dental and facial irregularities. Whilst there is a wide variation in what is considered 'normal' in the population, there are certain dental and jaw irregularities that are detrimental to health. Crooked teeth and teeth that do not fit together correctly are harder to keep clean, are at risk of being lost early due to tooth decay and periodontal disease, and cause extra stress on the chewing muscles that can lead to headaches, jaw-joint problems, and neck, shoulder and back pain. Teeth are an important part of the face and, if they are grossly mal-aligned, detract from one's appearance to such an extent that normal socialisation may be difficult.

Whereas the treatment of minor variations in tooth position can be viewed as merely cosmetic, the treatment of more significant malocclusions and jaw deformities that affect eating, speaking, chewing, breathing and socialising, are oral health conditions for which treatment is strongly advised.

The incidence of orthodontic conditions that are deemed to warrant treatment has been estimated at 29 - 33% of the UK population. An orthodontic Index of Treatment Needs is used as a measure of severity. A 2016 NDIP inspection of children in S3 in Shetland found 49% had an orthodontic condition that might be accepted for treatment within the NHS. This is higher than elsewhere, suggesting that the local gene pool may be slightly different, and that early preventive intervention of orthodontic conditions is less likely to have been carried out locally.

6.0 Dental Epidemiology

6.1 Dental Disease in Children

Vision 1:
All children in Shetland can develop and shed their deciduous teeth with no significant intervention from NHS dental services, and develop their adult dentition free from the two main dental diseases - dental decay (caries) and gum (periodontal) disease.

Figures for the oral health of Shetland children are available through the National Dental Inspection Programme (NDIP) that coordinates annual oral health surveys of children attending local authority-run schools and are published by the Information Services Division of the Scottish Government (www.isdscotland.org). The prevalence of dental decay experience, and whether this has been treated or not, is measured using the dmft index for primary teeth [d=decayed, m= missing due to decay, f=filled, t=teeth] and the DMFT Index for permanent teeth.

P1 children	Year	1988/89	2010/11	2011/12	2012/13	2013/14	2014/15
Mean dmft	Shetland	2.48		1.07		**0.64**	
	Scotland	2.88 (1990 fig)		1.52		**1.27**	
P7 children	Year	1988/89	2010/11	2011/12	2012/13	2013/14	2014/15
Mean DMFT	Shetland	2.54	0.46		0.35		**0.42**
	Scotland	2.23	0.70		0.60		**0.53**

Table 3: The mean decay experience of Shetland children in P1 and P7, by year of survey

These figures show that Shetland children in P1 and P7 have below-average levels of decay experience compared with the Scottish average, and the decay experience has been reducing over the past twenty-five years. A slight rise in the mean DMFT for Shetland P7 children was recorded in 2014/15. This rise can be attributed to decay in just four additional children, so may or may not be of significance.

P1 2013-14	**% with no obvious decay**	**d**	**m due to decay**	**f**	**dmft**	**dmft for those with obvious decay**
Shetland	80.9	0.38	0.12	0.15	0.64	3.3
Scotland	68.2	0.82	0.27	0.18	1.27	3.97
P7 2014-	**% with**	**D**	**M due to**	**F**	**DMFT**	**DMFT for**

5	no obvious decay		decay			those with obvious decay
Shetland	79.8	0.15	0.11	0.16	0.42	2.13
Scotland	75.3	0.18	0.07	0.29	0.53	2.16

Table 4: The dmft/DMFT index for children in P1 (2013-4) and P7 (2014-5) in Shetland

19% of P1 children and 20% of P7 children in Shetland were found to have experienced decay in the most recent surveys for which data is available. Although these figures are among the lowest of all Health Board areas in Scotland, they still show that around one in five children entering primary education have already experienced decay in their deciduous teeth, and around one in five children leaving it have already experienced decay in their adult dentition.

The Care Index is a measure of how much of the decay experience has been treated by fillings.

$$\text{Care Index} = \frac{\text{number of filled teeth}}{\text{number of obviously decayed, missing and filled teeth}} \times 100$$

For P1 children Shetland is second only to Orkney in the percentage of the decay that has been treated.

NHS BOARD P1 children	CARE INDEX		NHS BOARD P1 children	CARE INDEX
Ayrshire & Arran	15.0%		Highland	14.3%
Borders	15.3%		Lanarkshire	9.7%
Dumfries & Galloway	12.5%		Lothian	13.0%
Fife	14.4%		Orkney	27.6%
Forth Valley	15.8%		**Shetland**	**23.4%**
Grampian	16.0%		Tayside	16.9%
Greater Glasgow & Clyde	13.8%		Western Isles	21.1%
			SCOTLAND	**14.2%**

Table 5: The Care Index of P1 children by Health Board 2013-14

By this measure Shetland does not do so well in treating the dental decay of P7 children, and has the lowest Care Index among the Health Board areas for this age group.

NHS BOARD P7 children	CARE INDEX		NHS BOARD P7 children	CARE INDEX
Ayrshire & Arran	60.0%		Highland	48.6%
Borders	83.3%		Lanarkshire	45.0%
Dumfries & Galloway	61.1%		Lothian	52.1%
Fife	63.0%		Orkney	44.4%
Forth Valley	50.0%		**Shetland**	**38.1%**

Grampian	54.4%		Tayside	52.3%
Greater Glasgow & Clyde	54.8%		Western Isles	68.4%
			SCOTLAND	**54.7%**

Table 6: The Care Index for P7 children by Health Board 2014-15

It can be noted that the Island Boards are significantly better at treating P1 children than mainland Boards. This may be due to the much larger percentage of the Island Board P1 populations being registered with the PDS which are better able to co-ordinate dental treatment provision with Childsmile activities.

It has long been recognised that there is a gradation in the decay experience of children depending on the social background of the adults in the household, with around 30% more decay experience seen among the children from SIMD 1 (most deprived) households than in children from SIMD 5 (least deprived) households. These figures are not published at a Health Board level. Vision 4 of this Strategy is specifically aimed at reducing this inequality.

Vision 4:
Effective mechanisms are in place to overcome inequalities in oral health in the local population, with enhanced support and prioritisation being given to disadvantaged individuals and communities.

6.2 Dental Diseases in Adults

Vision 2:
All adults can maintain a healthy natural dentition through to later life with minimal need for artificial replacement.

Unlike the figures for children, the equivalent figures for the prevalence and treatment of decay in the Shetland *adult* population are not available, as the UK-wide decennial dental epidemiological surveys have only reported figures for Scotland as a whole, and have not been sufficiently detailed to provide information at a Health Board-level.

During 2008-2011 a series self-reported written questionnaires on the health of adults were completed throughout the United Kingdom, and these surveys included a question on the number of teeth present. In Shetland 71 per cent of adults aged 16 or over reported that they had 20 or more natural teeth, 10% had between 10 & 19 teeth, 6% reported fewer than 10, and 13% said they had no natural teeth. The comparable Scottish figures: 72%, 12%, 5% and 11% respectively, showed that Shetland people had very slightly fewer natural teeth than the national average. These figures are higher than for adults in England where, for instance, in 2009 6% of the English adult population had no natural teeth. Thus Scotland and Shetland are lagging behind in the steady decline in the proportion of edentulousness, a statistic that can only be reduced with the passage of time.

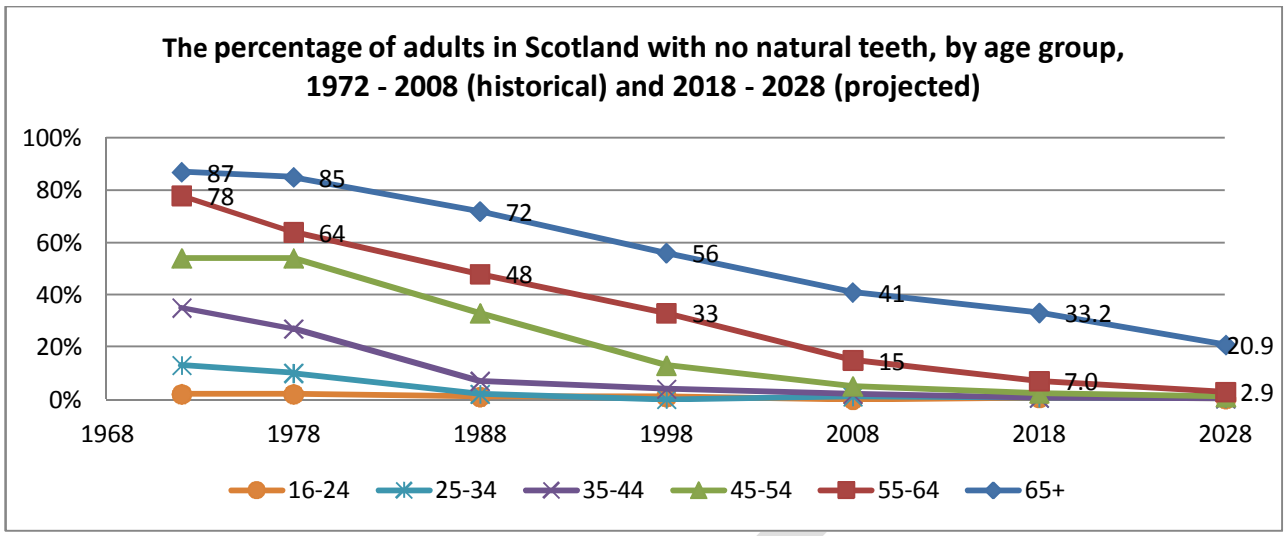


Figure 2: The percentage of adults in Scotland with no natural teeth, by age group

Over the last fifty years there has been a steady decrease in the number of people with no natural teeth. The percentages are heavily age-related, and the reduction is expected to continue. This reduction has implications for dentistry as the treatment provided for those with and without teeth is very different. Vision 2 is targeted at the oral health care of adults.

The expectation is that the overall oral health of adults will slowly improve as children without dental decay grow into adulthood. Even for those adults who do experience dental decay and gum disease the aim is for them to retain their natural dentition for as long as possible, hopefully throughout life, and for people to delay needing to wear dentures till later in life. Already more than half of people aged 85+ have retained some of their own teeth, and this proportion is set to rise year on year.

6.3 People with disabilities

Approximately 1 in 5 people in the UK are classified as disabled. Only 17% of disabled people are born with an impairment, and there is a strong correlation with age, with the majority of people only acquiring impairments in later life.

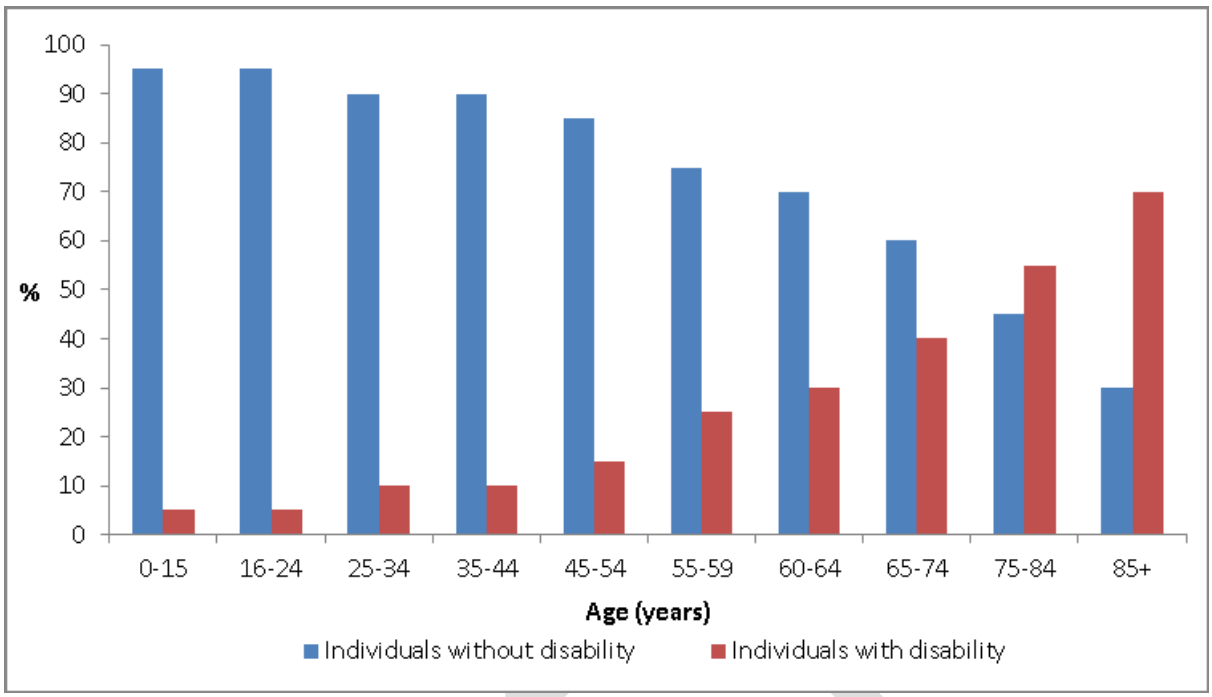


Figure 3: The Proportion of the UK population with a disability, by age group
Source: Age UK 2012.

The 2011 census returns for Shetland provide the following self-reported information on peoples' health status, including disabilities:

Total Population 23,167	**Number**	**% of population**
% with one or more long-term conditions	6927	29.9%
% with deafness or partial hearing loss	1529	6.6%
% with blindness or partial sight loss	556	2.4%
% with a learning disability e.g Downs Syndrome	116	0.5%
% with learning difficulty (e.g., dyslexia	463	2.0%
% with a developmental disorder e.g autism	386	0.6%
% with physical disability	1552	6.7%
% with mental health condition	1019	4.4%
% with other condition	4332	18.7%

Table 7: The self-reported incidence of health status, including disabilities in Shetland 2011

It should be noted that these figures include children as well as adults.

These figures are significant to oral health for two different reasons. Firstly, some of these conditions reduce the ability of the individual to be self-sufficient in oral hygiene, and therefore more prone to dental diseases. Secondly, people with some of these conditions will be more suited to oral health care being provided in the Public Dental Service than in an independent NHS practice.

7.0 Health Board Responsibilities

Health Boards are required to assess the oral health needs of the population, and implement plans to ensure the capacity of local oral health care services match the level of local need. This should be on the basis of meeting individual needs so that the desired outcomes for patients are achieved. As the pattern of dental disease has changed markedly since the inception of the NHS, new patterns of delivery are likely to be more effective than those delivered according to historic patterns.

Most Health Boards in Scotland employ a Consultant in Dental Public Health within the Department of Public Health to advise the Board on the state of oral health and the provision of oral health care in their geographical locality. In Shetland and the other Island Health Boards this role is incorporated in the post of Chief Administrative Dental Officer (CADO), which covers both management and dental public health responsibilities. The CADO is the strategic lead for oral health and dental services and provides direction and leadership in assessing local needs and planning local services

In assessing the needs of the local population, and determining how these needs can best be met, the Board will have an understanding of:

- The needs of different segments that make up the local population and how their needs differ, including patterns of oral health and service demand
- The oral health needs of specific communities or groups with unmet needs or comparatively greater health needs such as those with learning or physical disabilities
- How these needs compare with those across Scotland.

Planning dental service provision locally will take into account the range, type and complexity of services being provided, the geography of the area, and the population being served.

School inspections and epidemiological surveys such as the National Dental Inspection Programme (NDIP) are integral to the work of the Board, and help inform the local oral health needs assessment.

The majority of primary care dentistry is normally provided through a large number of general dental practices i.e. independent practitioners contracting with the NHS to provide NHS dental care to NHS expected standards. A separate Board-commissioned Public Dental Service will provide primary dental care for people for whom the General Dental Services are not suitable. The Board will also arrange for specialist oral health care where either the complexity of the work itself, or of the patient for whom it is being provided, are beyond what would normally be expected of a routine dentist.

New patterns of service provision are being developed whereby the division between primary and secondary care is being eroded. Managed Clinical Networks (MCNs) are being developed to ensure that each patient is treated by a clinician with the appropriate expertise to meet that patient's particular needs, irrespective of where the service is located. There are MCNs in operation in the North of Scotland for the provision of Orthodontics, Oral/Maxillo-facial Surgery, Paediatric Dentistry and Restorative Dentistry, and the Clinical Director/CADO of Shetland is a member of each of these groups. This collaboration with neighbouring Health Boards helps cross-boundary planning for specialist aspects of oral health care.

8.0 The Provision of Oral Health Care in Scotland

Nationally, NHS oral health care provision is available through four main service locations:

- In independently owned dental practices that contract to supply NHS care. The expectation is that the overwhelming majority of primary dental care will be provided this way.

- In clinics and other locations run by the Health Boards, the Public Dental Service (PDS). The PDS remit is specifically to provide primary care dentistry for the section of the population who, for whatever reason, are unable to access dentistry in the independent NHS practices.

- In hospitals, where consultant-led oral health care services diagnose and treat conditions that are beyond the scope of primary dental care services.

- In schools and other community settings where oral health-promoting activities can be delivered safely to the wider community.

In addition to NHS oral health care, there are a number of dental practices who do not contract to provide NHS dentistry, and offer care on a private basis. Because these practices operate outside the NHS they are able to provide a wider range of treatments than are available 'on the NHS.' From 2016 onwards Health Boards are expected to monitor the activities and quality of care provided by private practices.

8.1 Independent NHS dental practices

The overwhelming majority of primary care dentistry is provided within independently-owned and run dental practices that contract with the NHS to provide routine oral health care to the general population. These practices are paid by the NHS on an episode-of-care basis according to a fee scale, the Statement of Dental Remuneration. There is also a registration scheme in place to provide a long term patient/dentist relationship, for which the dentist receives a capitation payment (for children) or a continuing care payment (for adult patients). Patients pay a contribution towards the cost of their NHS care, currently 80% of the NHS fee up to a maximum of £384. Dentists need to obtain prior approval from the Public Service Division if the total cost of an episode of treatment is above £390. There are no patient contributions for the care of children under the age of 18, and there are exemptions for expectant and nursing mothers, some students, and people on a range of means-tested benefits.

8.2 Public Dental Service

The government has established the Public Dental Service (PDS) for people of all ages who are not suitable (for whatever reason) or able to receive their primary care dentistry within independent NHS practices. The PDS provides a similar range of clinical primary care dentistry but for a dissimilar population – people with special needs, and those requiring additional support. The PDS uses the same Statement of Remuneration as the independent NHS practices, and collects patient fees where applicable; however the dentists are paid a salary, to reflect that the treatment of people with special needs may be more time-consuming and/or complex than for the general population. The PDS also has additional public health responsibilities over and above its clinical role.

The PDS provides a wide range of services in a variety of settings, including community, custodial and secondary care settings. Its roles can be grouped into six main areas:

8.2.1 Priority group clinical services:
Dentistry for vulnerable groups - this is its key remit:

- Provision of a full range of treatment services to patients with special care needs, including:
  - people with significant learning disabilities,
  - people with significant mental health problems,
  - people with significant physically disabilities,
  - people with significant medically compromising conditions.

- Dental care for people who can have difficulties accessing independent NHS dental services:
  - Looked after and accommodated children
  - Frail elderly and housebound patients
  - Young offenders, prisoners and those in secure facilities
  - People with problems of substance misuse and dependency
  - Socially excluded groups e.g migrants and homeless people.

8.2.2 Behaviour management, sedation and general anaesthesia services:
Provision of a full range of dental care to adults and children with significant anxiety or phobias. These people may require:

- Behaviour management techniques - for "dentally phobic" patients. These should involve the use of psychological therapy colleagues.

- Inhalational or intravenous sedation services for people with moderate to severe dental anxiety. Usually this should be available within a primary care dental setting.

- General anaesthesia (GA). General anaesthesia is reserved for the most challenging patients, including children who are unable to co-operate, as well as some special care and severely compromised patients, and should be viewed as the last resort. Its use depends on the needs of the individual patient and the clinical work required. General anaesthetic services are all provided in an acute setting with appropriate critical care facilities, and the patients will be deemed in-patients for the purpose of tracking patients and activity through the service.

8.2.3 Patients referred for assessment and treatment:
- Referred from general dental practitioners for specialised and specialist services, for example special care dentistry, paediatric dentistry, sedation and general anaesthesia.
- Referred from other health and social care practitioners.

8.2.4 Dental public health role:
- Oral Health Promotion - the PDS provides oral health promotion programmes to groups and individuals in a range of settings, e.g. workplace and schools. However, PDS clinical settings are also used

to target particular individuals, for example, alcohol brief intervention and smoking cessation. Caring for Smiles is a national programme for ensuring residents in Care Homes receive oral health input, and that care home staff are trained in delivering personalised oral hygiene care when needed.

- National Dental Epidemiological Programme (NDIP) - this is a programme of annual dental inspections and epidemiological surveys of children's oral health, these currently are as follows.

  - *Basic Inspection* – a rolling programme which undertakes inspection of all Primary 1 and Primary 7 school children each year. The 'basic' NDIP workstream provides information to each child and their parent or carer about their oral health and risk of future dental disease.

  - *Detailed Inspection* - every PDS is required to engage in the epidemiological examination of a representative sample of Primary 1 and Primary 7 children required by the 'detailed' workstream of NDIP. This programme facilitates the production of anonymised, standardised, quality assured information about the dental health of P1 and P7 schoolchildren in alternate years. This data is used by Scottish Government and NHS Boards when planning services and addressing health inequalities. Clinical examiner(s) are identified from among the PDS staff, along with support staff for administration, recording and data entry, to allow all activities to be undertaken within the prescribed timescale. Members of the fieldwork team are expected to be supported to attend any necessary training and calibration events provided at national level.

8.2.5 Routine dental services:

- The PDS should complement the mainstream NHS provision; NHS Boards should manage the PDS to ensure that it does not duplicate service provision which the board is already funding through mainstream NHS arrangements. Routine dental treatment to the local general population should only be provided by the PDS in situations where efforts to attract an independent contractor have failed and there is a gap in general dental service provision.
- Day-time emergency dental services for unregistered patients, where there is no capacity within the independent contractor service to meet demand. Patients attending day-time emergency centres should be actively encouraged and supported to register with an independent contractor for ongoing routine care.
- In some NHS Boards, including Shetland, the management of out-of-hours services is the responsibility of the PDS. NHS Boards should facilitate participation in any Out-of-Hours rota by independent contractor dentists, PDS dentists and hospital dentists where appropriate.
- The PDS is central to contingency plans to maintain dental service delivery during emergencies, for example, pandemic flu, and should be included in NHS Board contingency planning.

8.2.6 Teaching and research:

The PDS makes a significant and invaluable contribution to the education and clinical training of the dental team in Scotland by ensuring adequate access to patients appropriate for teaching. Through partnership and with funding from NHS Education for Scotland the PDS may deliver:

- Outreach training for undergraduate dental students,
- Outreach training for undergraduate hygiene/therapy students,
- Pre and post-qualification training for dental nurses,
- Clinical placements for vocational, core and specialty trainees.

Services can contribute to dental health research and to the development and piloting of good practice guidance documents for the profession by working in partnership with the dental schools, the Scottish Dental Practice-based Research Network (SDPBRN); the Scottish Dental Clinical Effectiveness Programme (SDCEP) and the Scottish Intercollegiate Guideline Network (SIGN).

As PDSs are hosted within a health and social care structure under an Integration Joint Board, this provides the opportunity to work closely with other health and social care providers.

8.3 Hospital Dental Services

Oral Health care that is beyond the scope of primary dental care services is provided in a secondary care setting by consultant-led services. Orthodontics and Maxillo-facial surgery are the two main services, along with Restorative Dentistry, oral medicine and several other smaller specialities. Provision of the acute-based oral health specialities in remote and rural environments is complicated by the fact that the population's needs are not sufficient to warrant full-time posts.

9. 0 Current Oral Health Care provision in Shetland

VISION 5:
All the population can access high quality, affordable, safe, and effective NHS oral health care services.

9.1 Dental registrations of the Shetland population

Between 2011 and early 2016 there were no independent NHS dental practices in Shetland, a situation that was unique within Scotland, and indeed the rest of the United Kingdom. This resulted in the Public Dental Service having to pour its efforts and resources into providing routine dentistry for routine patients to fulfil its 'safety-net' remit. (See Para 8.2.5)

Despite there being no independent NHS practices in Shetland during this time, a small minority of people have held registrations with independent NHS practitioners elsewhere.

The following Table 8 demonstrates the numbers of Shetland people registered with different dental services over the past eight years. It also shows clearly the effect the last remaining independent NHS practice in Shetland closing in 2011/2.

Date	2007	2008	2009	2010	2011	2012	2013	Mar 2014	Sep 2014	Mar 2015	Sep 2015
PDS	5937	7062	9174	10908	11990	14206	17574	17965	18117	18389	18492
Indep NHS	3896	4099	4071	4105	4141	3018	526	519	535	547	711
All	9044	11057	13245	15007	16119	17224	18110	18447	18484	18936	19203
% of adults regist	38.1%	45.0%	52.9%	59.8%	64.8%	70.1%	74.4%	75.8%	76.8%	78.4%	80.0%
% of children regist	48.5%	63.5%	76.2%	83.6%	85.7%	89.2%	91.5%	93.6%	93.4%	93.1%	92.8%

Table 8: Numbers and percentage of Shetland people registered for primary care dentistry by year

This pattern will gradually change, though, following the opening of a four-surgery independent NHS dental practice in Lerwick in January 2016 with the avowed aim to register at least 6,000 for routine NHS dental care.

However, the PDS will continue to need to provide routine dental services until such time as there are several independent NHS practices open throughout Shetland with sufficient capacity to accommodate the whole mainstream population.

Numbers of dental registrations have been increasing steadily since the introduction of non-time-limited registration. Prior to April 2006, patient registration lapsed after a period of 15 months if the patient did not attend the dental practice. This was extended to 36 months from April 2006 and further extended to 48 months from April 2009. In April 2010, 'lifetime registration' was introduced, i.e. the patient will remain registered with that dentist unless they move to another dentist, or upon death. These extensions to the registration period have had, and will continue to have, an impact on registration rates.

For Shetland *children* the registration rate is currently the second highest of any Health Board, after Greater Glasgow, (but despite this is still marginally below the Scottish rate of 93.4%). For *adults* Shetland has the ninth highest percentage of registrations, below the average Scottish figure of 88.4%. This is not surprising because of the long-standing shortfall in primary dental care services in Shetland. Comparative figures need to be treated with caution however, as there is a considerable cross-border flow of people who live in one area but register for dentistry in a different area, such as near to where they work.

In view of the changes to the registration system it cannot be assumed any more that registered people are attending their dentist regularly. At the same time that registration rates have been rising, participation rates (defined as the percentage attending the dentist in the previous two years) have been steadily reducing, a statistical consequence of the changes.

Date	Nos	%	Nos of	%	Nos of	%

	participating – All ages	participating – All ages	Children participating -	Children participating	Adults participating	Adults participating
2007	8626	95.4%	2412	97.2%	6214	94.7%
2008	10426	94.3%	3206	99.5%	7220	92.2%
2009	11849	89.5%	3624	93.2%	8225	87.9%
2010	12963	86.4%	3787	88.5%	9176	85.5%
2011	13824	85.8%	3955	90.5%	9869	84.0%
2012	14086	81.8%	3971	88.9%	10115	79.3%
2013	13765	76.0%	3867	85.5%	9898	72.9%
Mar 2014	13384	72.4%	3890	85.2%	9494	68.2%
Sep 2014	13036	69.9%	3860	84.8%	9176	65.1%
Mar 2015	12745	67.3%	3784	83.4%	8961	62.2%
Sep 2015	12171	63.4%	3622	80.1%	8549	58.2%

Table 9: Numbers and rates of people registered with a Shetland address who have participated (received NHS dental care) during the previous two years

The number of people participating in Shetland reached a peak in 2012 and has been dropping slowly since then. This is almost certainly because, with a shortfall in the capacity of primary care dentistry in Shetland, the Public Dental Service has been prioritising people with known treatment needs over people requesting (lower priority) recall examinations. Treatment takes longer than routine examinations, so less people have been seen. Understandably this prioritisation has been criticised by people wishing to have regular routine examinations, many of whom consider a 'six-monthly' check-up a human right. [In fact, since the inception of the NHS there has never been a 'six-month' examination; the idea developed because dentists were not paid for check-ups less than six months apart]

The figures in the tables above refer only to people registered with *NHS* dental services. They do not include people attending for private dental care, for which figures are not known. Therefore the figures for Shetland, where there are two private practices, are likely to be an under-estimation of the true picture.

9.2 Independent NHS Dental Practices

Currently (June 2016) there is one independent NHS dental practice in Shetland located at 4 Market Street Lerwick, with two dentists and vacancies for two more. This practice opened in January 2016 and is said to have approximately 1200 registrations so far.

Additional NHS practices may be expected to open in due course and should be welcomed, as competition will help to ensure quality, with patients drifting to the practice that is most able to meet their expectations.

However, it is difficult to envisage this competition operating in rural areas, especially when it is likely that the independent NHS practitioners will only want to locate their practices in urban areas with a sufficient population.

9.3 Public Dental Service

VISION 4:
Effective mechanisms are in place to overcome inequalities in oral health in the local population, with enhanced support and prioritisation being given to disadvantaged individuals and communities.

The Public Dental Service has been the sole provider of NHS primary care dentistry in Shetland between 2011 and January 2016, fulfilling both its PDS remit and also its safety net function to provide primary care dental services to the wider population. Activity is provided in six clinic locations, three in Lerwick (10 chairs) at Montfield, St Olaf Street and the Dental suite Gilbert Bain Hospital, and three clinics (5 chairs) elsewhere in Brae, Mid Yell and Whalsay Health Centres. This capacity has been insufficient in Brae and Lerwick for the numbers of people wanting to access the service, and waiting lists for adults wishing to register have been maintained at both locations. Children, and people with Special Needs, were registered without waiting. With an independent NHS practice now open in Lerwick, the PDS Lerwick waiting list has been closed. Any reduction in waiting list numbers is dependent on how quickly the practice can attract and maintain new registrations.

The PDS has a monthly operating list for treating people under general anaesthesia held in Main Theatres, Gilbert Bain Hospital. These comprise of pre-cooperative children requiring dental extractions, phobic adults requiring treatment beyond their ability to accept, and people with learning disabilities or other special needs who are unable to cooperate for the treatment needed.

The PDS has a daily 'emergency dental service' where people with pain of dental origin and similar problems are seen for urgent dental care. People are triaged according to need, and prioritised as necessary. They may be people who are registered with the Shetland PDS, and people who are not. The latter category include temporary workers in the oil, gas, fishing and construction industries, as well as visitors, tourists and cruise ship passengers. Although many of these people hold dental registration elsewhere, the Health Board is still responsible for providing an emergency service for them until they can return to their usual dentist. Whenever possible, unregistered people are diverted to the independent NHS practice in Lerwick who are keen to register and treat them.

Dentists from the PDS also run an out-of-hours emergency dental service every day of the year, linked to NHS 24.

The PDS remit includes the local provision of Oral Health Promotion and Education. This includes the national Childsmile programme, the National Dental Inspection Programme, Caring for Smiles and other ventures designed to raise the knowledge of oral health and disease in the local population and supply the clinical components of the prevention programmes.

The effectiveness of Childsmile can be evidenced from the following table, which shows how the number of children requiring teeth to be removed under GA dropped sharply, with the younger age group demonstrating the reduction before the older children:

Shetland Patients admitted to hospital who have a diagnosis of Dental Caries and whose treatment was tooth removal

Year	*Children aged 15 and under*	*Of which, aged 4 and under*
2004	***27***	***10***
2009	***31***	***3***
2014	***9***	***2***

Table 10. Shetland Patients admitted to hospital who had a diagnosis of Dental Caries and whose treatment was tooth removal

The PDS provides screening to people in Care homes, as part of the Caring for Smiles initiative, and domiciliary care for people of all ages who are unable to access clinic/surgery based locations. The majority of these are elderly people with frailty, but there are also small numbers of younger people with medical, physical and/or psychiatric conditions.

9.3.1 Public Opinion of the Public Dental Service in Shetland

There has been local public criticism of the perceived difficulty in registering for dental care in Lerwick, for the difficulty in obtaining timely dental appointments, for the lack of automatic 'six-monthly' recalls, for the slowness of treatment requiring the work of a dental laboratory, and for a long waiting list for orthodontic treatment.

A Patient Satisfaction Survey of 511 PDS patients, carried out in November 2014, showed that patients were generally happy with the service they receive, when they can access it. Satisfaction was reduced when appointment-booking was included.

In summary:

94% of the 511 were Very satisfied or Satisfied with the overall service they had received that day.

Only two people said they were Dissatisfied or Very Dissatisfied. (The reason given by one of these was that they wanted White Fillings in posterior teeth, which are not allowed to be carried out as an NHS treatment).

98% were satisfied or very satisfied (happy) with the cleanliness of the clinic

97% were happy with reception staff

97% were happy with the care and attention given by the clinical staff

97% were happy with the explanation of their planned treatment

97% were happy with the clinic facilities

93% were happy with the access to the building

89% were happy with the waiting room

89% were happy that they had been seen on time for their appointment

87% were happy with the advice given to the after treatment. (Another 9% did not answer the question as they did not have any active treatment that day.)

85% were happy with patient-clinic communications

79% were happy with the flexibility and choice of appointment times

76% were happy about booking another appointment (Another 13% did not answer the question, presumably because they did not need to book another appointment.)

Overall these results showed that people were, on the whole, happy with the service provided, but there are some issues around booking appointments. The reason for the difficulty can be ascribed to a shortfall in dental capacity in Shetland i.e there are insufficient dentists to meet the needs of the local population. In Scotland as a whole the ratio of dentists to the population is roughly 1 dentist per 1300 people, whereas in Shetland the ratio has been over 1 per 2500. This has meant there have been no empty spaces in appointment books waiting to be filled at short notice, there have been many patients at any one time with open courses of treatment, and treatment cases have been prioritized over people simply requesting a 'six-monthly' dental examination.

9.4 Private dental practices

There are two totally private dental practices, both located in Lerwick with a total of three regular dentists and occasional additional associates. These practices are estimated to have seen around 1500 different people, with some people attending for routine care, and others attending for specific treatments that are not available within the NHS, such as white fillings in posterior teeth. One dentist specialises particularly in advanced restorative dentistry i.e treatments requiring the work of a dental technical laboratory.

As part of her Programme of Government speech in September 2015 the First Minister for Scotland announced that arrangements would be introduced to require the inspection and regulation of a range of private health clinics including private dental practices. Further details are awaited; however the expectation is that this will be a Health Board responsibility. (See Para 1, p7)

9.5 Orthodontics

A Consultant from Grampian visits Shetland six times per year to diagnose and treat orthodontic problems, especially the small number of people who require the combined expertise of orthodontics and maxillo-facial surgery who will receive care, partly in Shetland and partly in Aberdeen.

The majority of routine diagnosis and treatment of orthodontic problems however is provided by a visiting Orthodontic consultant who comes to Shetland regularly on a locum basis.

Orthodontic provision in Shetland is limited to those most needingtreatment. Only cases that are above 3.6 on the Index of Orthodontic Treatment Needs (IOTN) are accepted for treatment, and prior approval has to be obtained from the Practitioner Services Division before treatment can be commenced.

Capacity for orthodontics is insufficient for the number of cases locally, which has resulted in the average age for referral and treatment rising well above 12 years, the optimum age for treatment. This causes the dual drawbacks of slower treatment and the exclusion of certain types of treatment that would capture the adolescent growth spurt and simplify treatment.

Orthodontic Therapists are Dental Care Professionals who are trained to provide routine hands-on treatment working under the supervision of an orthodontist. If there was a post in Shetland for such an individual, the efficiency of the orthodontic service could be greatly enhanced.

9.6 Maxillo-facial Surgery services

Maxillo-facial surgery is a surgical specialism carried out by surgeons with dual qualifications. As part of the Health Board agreements arrangements with Grampian, a consultant-led team from Grampian visit Shetland to provide maxillo-facial surgery in Gilbert Bain Hospital. This service includes assessments and outpatient appointments as well as operating under general anaesthesia in the main theatre suite.

This arrangement provides routine Maxillo-facial surgery needs of the population, with urgent cases, and those requiring extensive surgery, being transferred to Aberdeen Royal Infirmary for treatment. Maxillo-facial surgery divides into two specialist streams, with surgeons tending to specialise further in either head-and-neck surgery for tumours, or for the treatment of clefts and other embryological and neo-natal deformities.

Currently the visiting maxillo-facial team also undertake a range of simpler surgical operations under local anaesthesia which could be carried out in a minor operations room. This would free up theatre time for other specialities.

Some of these simpler surgical operations come under the remit of oral surgery, and could be carried out by a locally-based singly-qualified specialist with sufficient skill and experience if there was such a post in Shetland.

9.7 Restorative Dentistry

Restorative Dentistry is the study, examination and treatment of diseases of the oral cavity, the teeth and their supporting structures. Restorative dentistry includes the mono-specialities of endodontics, periodontics and prosthodontics (including implantology).

There are a small number of people requiring restorative dentistry whose needs are beyond the scope of primary care dentists, and whose treatment is outwith the Statement of Dental Remuneration which determines what NHS care can be provided in a primary care setting. There is no agreement with Grampian for Restorative Consultant visits to Shetland, so patients are referred to Grampian on an individual basis for diagnosis, treatment planning, and treatment too if this is not possible in Shetland.

9.8 Dental Laboratory Services

There are no dental technical laboratories located in Shetland currently. This slows the provision of treatment requiring dental laboratory work, such as bite-guards, removable orthodontic appliances, dentures, crowns and bridges, as mainland laboratories are used and work is posted back and forth. This also leads to a reduction in the quality of denture provision due to impressions distorting and deteriorating whilst in transit. An island-based dental technical laboratory would be ideally placed to provide this aspect of oral health care and raise quality. Additionally provision could be enhanced through a local Clinical Dental Technician, who would be registered by the General Dental Council to provide dentures

independently of dentists. With its higher numbers of older people, and a higher percentage of denture-wearers, Shetland would be an ideal location for such a post.

10.0 A Vision for Quality

The Health Board is determined that both the reality and perceptions of quality oral health services should be embedded in the independent and the Board-provided NHS services.

The Public Dental Service has a clinical governance framework in place to help ensure an environment of continuing quality improvement.

The Health Board will seek assurance that the independent dental practices in their area also have quality embedded at the heart of their services. This is possible through practice inspections carried out by the Dental Reference Officers of PSD, and those carried out by the Health Board itself. The expectation is that Oral Health care services in Shetland will meet or exceed the Health Improvement Standards (2006) and have monitoring systems in place to ensure compliance.

10.1 National Standards for Dental Services

The National Standards for Dental Services in Scotland (2006) cover each stage of the patient pathway through dental services and are designed to show what quality should look like in practice:

1. People have access to accurate and easy to understand information that is readily available to help them choose the dental service that best meets their needs.

2. People receive all the information they need in advance, to help them when they attend their appointment.

3. People are treated with dignity and respect by the dental team throughout their visits.

4. All decisions on patient dental care, including preventive care, will be based on a full assessment of their needs.

5. Peoples' decisions on any care and treatment provided to them by the dental team are based on them being fully informed by their dentist of the risks, benefits and costs involved.

6. Patients receive safe and competent care and treatment in a manner designed to put them at ease.

7. Following their consultation, investigation or treatment, patients know about, and agree, the ongoing care they need and the arrangements for providing it, including whom is to provide it.

8. Patient care and treatment is provided according to recognised current best practice guidelines.

9. The dental service will welcome and actively seek their views to help it continuously improve the quality of care it provides.

10. The service keeps a full and up-to-date record of all aspects of patient care. It uses and stores it in a manner that ensures their confidentiality, and is in line with current legislation.

11. Patient care and treatment will be provided by a dental team who are suitably qualified or skilled (or both) for their job.

12. If there is an emergency while they are attending the dental service, the dental team is trained to deal with it.

13. The dental service takes every reasonable precaution to make sure patients are not exposed to the risk of infection.

14. The design, layout and facilities of the dental service will support the safe and effective delivery of patient care and treatment.

15. The care and treatment that children and young people receive from their dental service take account of their special physical, psychological and social needs, and are provided in partnership with parents or guardians.

10.2 Expected Oral Health Outcomes

The expected outcomes for patients of the dental services in Shetland are based around enabling individual long-term oral health with a minimum of professional intervention required.

Using the Health and Wellbeing outcomes of the Public Bodies (Joint Working) (Scotland) Act 2014, already quoted on page 9, these have been adapted to focus on the oral health of the local population, namely:

1. People are able to look after and improve their own oral health and wellbeing and live in good health for longer.

2. People, including those with disabilities or long-term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community, supported by carers who are able to support their oral health and hygiene needs.

3. People who use oral care services have positive experiences of those services and have their dignity respected.

4. Oral health care services are centred on helping to maintain or improve the quality of life of people who use these services

5. Oral health care services contribute to reducing health inequalities

6. Carers are supported to look after their own oral health and wellbeing including to reduce any negative impact of their caring role.

7. People using oral health care services are safe from harm.

8. People who work in oral health care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

9. Resources are used effectively and efficiently in the provision of oral health care services.

11.0 An assessment of specialist dental services in Shetland

There has been a long-standing programme of occasional visits from Grampian by consultants in Maxillo-facial Surgery and Orthodontics, timed mainly to avoid breaching the SG's referral-to-treatment waiting times, but there has not been any recent assessment of the level of need for specialist dental services in Shetland.

It can be considered that there are four levels of dental expertise that patients should be able to access to meet their individual care needs. These are:

i) Level 1 care.
This level will be adequate for the majority of dental care required by patients, and is what dentists would be expected to deliver on completion of undergraduate and dental foundation training. With further experience, primary care dentists will be working at a skill level above this minimum level required for dental registration. The majority of Level 1 dentists work in general dental practice, and some work in the PDS as Dental Officers.

ii) Level 2 care.
This level of care is provided by dentists with a special interest (DwSI) in a particular aspect of dental care, who have additional knowledge and competence in a certain aspect. They may have an additional postgraduate qualification, and in a PDS might be employed as a Senior Dental Officer.

iii) Level 3 care.
This level is provided by clinicians who have completed training and shown competences suitable to be registered on a Specialist Register of the General Dental Council (GDC). There are 13 different specialist registers. Level 3 clinicians will often be employed in the hospital sector, or in specialist practice, or be employed as a Specialist Dental Officer in a PDS.

iv) Level 4 care.
This level is provided by clinicians who were not only on a Specialist Register, but also employed as a Consultant in their particular field, having completed the required additional training and gained the additional experience necessary.

The overwhelming majority of people will receive all their dental health care needs from Level 1 clinicians. However, occasionally they may be referred to a higher-level clinician to receive a diagnosis and/or for specific treatment. Once this is completed, the patient is referred back to the original level 1 clinician. This process enables oral health care to be carried out in the most cost-efficient way.

For people with Special or Additional Needs, it is the patient him/herself who is complex to treat, and even relatively simple treatments may need to be carried out by Specialists in

Special Care Dentistry, and the patient may require treatment under sedation or general anaesthesia.

In Shetland, the range of NHS dental care from level 1 to level 4 is limited can be tabulated as follows:

Dental Care / Specialism	Level	GDS and PDS	GBH	Grampian
Routine dental services	L1 & 1+	Yes		
Paediatric dentistry	L1+	Yes	Sedation & GA available in PDS/GBH	L3/4 in Grampian
Special Needs Dentistry	L1+ & 2	Yes in PDS	Sedation & GA available in PDS/GBH	L4 in Grampian
Orthodontics	L1, 2 & 3 L4	No Yes in PDS/GBH	- Visiting consultants, one as locum	- Multi-disciplinary surgical correction of jaw deformities
Oral Surgery	L1+ L2, 3 & 4	Yes in PDS Yes in GBH	- Activity by visiting OMFS consultants	L3/4 in Grampian
Maxillo-facial Surgery (is a Surgical speciality)	L4	No	Visiting OMFS consultants	L4 in Grampian
Restorative dentistry, incl sub-specialities*	L1 & 1+	Yes		L3/4 in Grampian
Dental Public Health	L3 (CADO)	In PDS		
Oral Medicine	-	No	-	L4 in Grampian
Oral pathology,	-	No		L4 in Grampian
Oral radiology	-	No		L4 in Grampian
Oral microbiology	-	No		L4 in Grampian
Key: * Sub-specialities of Restorative Dentistry are Periodontics, Endodontics and Prosthodontics				

Table 11: The Location and Complexity of Dental Specialist services in Shetland and Grampian

Whilst it is understandable that the very small dental specialities do not require a regular presence in Shetland, some of the other specialities have sufficient patient numbers to warrant having a local service.

Vision 6:

The vast majority of people requiring specialist oral health care can receive this in Shetland.

Most oral health care can be carried out in a routine dental surgery with the possible exceptions of: - Conditions when there is a need for specialised clinical or surgical equipment

- Treatment for patients with high-risk medical conditions where critical care facilities are available
- Treatments requiring general anaesthesia, which must be located in a secondary care facility.

These exceptions are already being provided at Gilbert Bain Hospital.

Currently there is a lack of local clinicians able to undertake the middle complexity (L2 and L3) treatments in almost all specialities, resulting in more patients being referred to Grampian, thus incurring travel costs in addition to treatment costs. Access to post-graduate training for Shetland-committed PDS dentists would be ideal, enabling the PDS to provide local care at levels 2 and 3 and the independent NHS practices to supply the majority of the level 1 care.

Orthodontic services in particular would benefit from being re-designed to increase the availability of local care considerably. Need has been exceeding local availability for an extended period, resulting in a large and ever-increasing backlog, currently around five years. There therefore needs to be five year's worth of double provision in order to treat the backlog alongside the new cases.

12.0 Planning for Special Care Dentistry in Shetland

In addition, to the locations and levels of care provided, the changing nature of the local population - with greater numbers of older people and those people also living longer – will have additional implications for the provision of Special Care dentistry. There will be an increasing need for dentists with the knowledge, skills and expertise to treat this expanding patient group.

The additional issues to be faced with the changing demography are:

- More domiciliary care of older people, either in their own homes or in a homely setting
- An increasing incidence of frailty, leading to a more proactive need to support people who are unable to look after themselves or their own oral healthcare
- An increased incidence of dementia, increasing the need for a skilled dental workforce to provide wholistic and supportive oral health care at a time when patient acceptance and compliance is compromised
- An increasing challenge to maintain bridges, implants, and other items of 'advanced restorative care' that were purchased by older people when they were younger, and are no longer appropriate
- An increased number of partial dentures in the older population, as against full dentures, leading to an increase in root caries.

These challenges can be met through:

- More training for the dental workforce in geriatric dentistry
- More training of carers in the oral health care of their charges
- A realignment of skill mix in the oral health workforce
- More oral health promotion input into the elderly population – an expansion of the current Caring for Smiles programme to target people in their own homes as well as in Care Homes
- More oral health care input into palliative care situations
- Pre-planning of people's oral status in the early stages of dementia to reduce or avoid the need for difficult treatments once the patient is unable to consent or cooperate.
- An increase in the need for dental services to be accessible, both for disability access and also geographical proximity
- Longer appointments needed to match the speed of the patient
- More inter-agency working
- An increased reliance on transport services
- More clinics adapted for wheel-chairs

Although most dentists in the PDS in Shetland are already working at a Level 2 in Special Care dentistry, there are no specialists or consultants in Special Care dentistry to support them currently.

Shetland, then, would benefit from having a greater emphasis on the recruitment of dentists able to supply the complexities of dentistry required by the local population, without needing to send patients to distant services for their care.

These challenges for dentists working with older people reflect the Scottish Government position published in 2013 by the Scottish Public Health Network: Health and Social Care of Older People in Scotland Policy Landscape:

- Developing person-centred services
- Delivering quicker, more personal care, closer to home
- A shift of care from hospital to community
- A shift towards prevention
- Targeting action in deprived areas
- Developing a systematic approach to managing long term conditions
- Supporting older people to lead more independent lives
- Valuing older people
- Improving support for carers
- Greater involvement of patients and carers in the design of services
- Developing an asset-based approach to health
- Encouraging people to take greater control over their own health;
- Promoting co-production, i.e delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours
- Agencies working together more effectively, with the integration of services
- Using an outcome based approach to improve outcomes that are relevant to patients and their carers, with an increasing focus now on shared outcomes.

ScotPHN (2013) Health and Social Care of Older People in Scotland Policy Landscape published 2013.
http://www.scotphn.net/pdf/2013_04_24_Final_Older_People_Policy_Landscape.pdf

13.0 Shaping Oral Health Services in Shetland for the Future

A national Plan for Oral Health is expected to be published by the Scottish Government in 2016 which will help set the direction and speed of travel for Shetland's Oral Health Strategy. A change to the dental contract for treating children has already been announced, but details of this, and of other developments, are awaited.

This Shetland Oral Health Strategy outlines the issues around local oral health care, and provides recommendations for improving the capacity, quality and sustainability of local services in both the employed and independent sectors.

The following issues are seen as fundamental:

13.1 A continuing emphasis on prevention to people of all ages

It is clear from the success of the Childsmile programme that a continuing investment in oral health promotion and the prevention of disease, will pay dividends.

An upward extension of the Childsmile-targeted age group to include teenagers is planned by Scottish Government, and changes to the NHS remuneration scheme for dentists to encourage more prevention was announced by the First Minister in her Programme for Government speech on 1st September 2015.

The cost of *not* emphasising prevention is considerable over a life-time, with this cost shared between the patient and the Health Board. Each carious tooth that is restored uses NHS resources. Each replacement restoration of the same tooth in the future increases the cost. Each tooth that is replaced by a denture uses NHS resources. Each replacement denture in the future further increases the overall cost to the NHS. There is also the cost of treating periodontal disease and oral cancer.

13.1.1 Maintain/increase Childsmile activities to meet new Scottish Government targets for P1 and P7 children

Independent NHS practices can choose to undertake Childsmile activities for their registered population, and the HB will encourage this, supporting practice staff to be effective in Childsmile delivery.

The PDS is likely to continue to have the major role in providing Childsmile activities for the foreseeable future, with its in-reach into education and nursery establishments, as well as to the parents of individual children through the practice-based aspects of the Programme.

This is especially important in the period of this Strategy as in March 2016 the Scottish Government issued new more challenging targets for the percentage of children that should be caries-free in P1 and P7, raising the targets from 80.9% and 79.8% respectively by 2022 to 89.0% and 87.8%. These new figures will be extremely challenging for Shetland, requiring excellent cooperation between the PDS and independent contractors to achieve them.

13.1.2 Maintain/increase Caring for Smiles activities

More effective individual daily oral healthcare can increase well-being in the individual, and reduce the need for professional clinical interventions.

As the average age of the local population is increasing and the number of older people is also increasing, the Board will ensure that the Scottish Government Caring for Smiles initiative is further developed to reach not only people living in Care Homes but also those in the wider community being supported by relatives and carers. The programme seeks to train Carers in how to care for the oral health of the people they care for, and proving oral health education to more and more people in the local population.

13.2 Build the capacity of primary dental care services to meet the oral health care needs of the whole population, including Occasional urgent treatments for visitors and temporary residents.

For many years Shetland has had a shortfall in the capacity of NHS dentistry to meet the needs of the local population and visitors. Put simply there were insufficient dentists working in Shetland for the Shetland population.

The opening of an independent NHS dental practice in Lerwick in 2016 potentially increases local dental capacity but only if the Public Dental Service remains at its present size carrying out its 'safety-net' role. Any premature reduction in the PDS will negate the potential increase in capacity that the new practice provides. There remains scope for several new independent NHS dental Practices to open. The Scottish Dental Access Initiative (SDAI) is designed to encourage practices into under-dentisted localities; but even with this the perceived financial risk for dentists contemplating setting up a new practice may be simply too great, especially in an unfamiliar geographical location.

The Health Board will continue to encourage dentists to set up dental practices in Shetland sufficient for all the local population, and also with spare capacity to see visitors to the islands needing emergency pain relief and care.

Around 15-16 WTE primary care dentists in independent NHS practices are required in Shetland, each having around 1500 registered patients. This should be the main source for the population to receive NHS primary dental Care.

In June 2016 there were just 2 such dentists in Shetland, plus two vacancies, leaving a shortfall of 13 – 14 dentists required in independent NHS dental practices.

The figure of 1500 is based on the Scottish Government expectations for dentists applying for Dental Access Initiative grants, and is close to the national average of dentists per head of population.

13.2.1 Encourage an equitable spread of independent NHS dentistry across the islands.

Realistically, market forces alone will not provide an equitable spread of NHS practices throughout Shetland. The optimum size for a dental practice dictates that it is not realistic for scattered rural areas and small island populations to attract independent NHS dental contractors. The Health Board will therefore continue to need to support the provision of primary dental care to the mainstream population in more remote districts and

islands through the PDS under its safety-net remit. This will in turn help support the PDS to maintain a reasonable spread of sites for provision of dentistry to people with special or additional needs.

Meanwhile the Board will seek to find a way to support rural independent NHS dental practices which is equitable and acceptable to the other, less-supported, practices.

Based on the spread of the population registered for GP services, the spread of dentists should be roughly:

Location	Recommended nos of independent NHS dentists (wtes)	Current nos independent NHS dentists		Current nos *including* permanent PDS dentists
Lerwick	6	2 (+ 2 vacancies)		7.4
Scalloway	2.2	0		0
Levenwick	1.8	0		0
Brae and Northmavine	2.4	0		2.4
Whalsay	0.8	0		0.8
Westside	1.2	0		0
North Isles	1.1	0		0
Total	**15.5**	**2**		**10.6**

Table 12: An ideal spread of NHS dental contractors based on the location of GP registrations

There remains a major task to encourage recruitment of 13 – 14 independent NHS practitioners to all areas of Shetland. Until this recruitment is successful it is not prudent to make major changes to the PDS which is currently filling a large proportion of the shortfall.

13.2.2 Recognise the PDS will keep a 'safety net' role, especially in the more remote locations including the populated islands.

It will remain important for the Health Board to recognise that whilst the PDS should be able to reduce its safety-net service to the regular population to an extent, it will need to maintain significant levels of routine dentistry for the more remote areas of Shetland, and to the populated islands.

Annual Island visits to Fair Isle, Foula and Skerries for dental examinations will need to continue, with residents making their own arrangements for active dental care if needed.

Any decision as to where an independent contractor will set up a practice is not for the Boards to take, but the Board can influence the decision through its application of the Scottish Dental Access Initiative, limiting the designated geographical area for new bids. The Board considers that new NHS practices will continue to seek to open in Lerwick until this market is saturated. Only then will they seek to locate elsewhere in Shetland, perhaps seeking the next-most populated areas of Scalloway, Levenwick and Brae.

However, for the later practice arrivals the financial risks associated with starting up in a lesser-populated location are immense. The Board will continue to look to the PDS to support these locations in the absence of any local independent contractor.

13.3 Support independent NHS dentistry, including a focus on quality.

Although independent NHS dental contractors are, as the name indicates, independent from the Health Board, they are listed by the Health Board, and that listing is dependent on them fulfilling their NHS contract to provide primary care dentistry to a reasonable quality. A general dental practice is wholly responsible for the quality of its services, but the Health Board maintains the responsibility to ensure that this is so. Ultimately the Health Board has the responsibility to protect the local population and the duty to close any practice unable to provide safe dentistry.

The Health Board will want to support local independent NHS practices to continue in business, and to continue to provide high quality services.

The Board will support the Area Dental Committee (ADC) as a forum for the coordination of local NHS dentistry and maintaining clinical quality.

13.4 Develop an Island-wide training plan and a continuing development plan for clinicians

Two local initiatives that would help the Board achieve its Aims in this field are to develop a wider plan for training local professionals complementary to dentistry (PCDs), and to support a local dental clinical governance/ quality/Continuing professional development group.

The development of a Shetland-wide training plan for dental care professionals would help to provide well trained qualified staff for local dental practices, help provide local people find local employment, and assist dental services maintain clinical quality.

The current PDS Dental Nurse training programme should continue, and possibly expand into additional areas of PCD training.

Establishing a local forum for dental receptionists would help enhance this role that is crucial for the quality of the dentist-public interface.

Independent NHS practices can choose to undertake Childsmile activities for their registered population, and the HB will encourage this, supporting practice staff to be effective in Childsmile delivery. This is especially important in the period of this Strategy as the Scottish Government have issued new targets for the percentage of children that should be caries-free in P1 and P7 by 2022, [89.1% and 88.0% respectively.]

13.5 Develop a range of local clinicians able to provide complex care, in particular people with expertise in orthodontics, oral surgery, Special Care Dentistry, paediatric dentistry and perhaps restorative dentistry.

The desired remit of the Public Dental Service is set out on pages 22-24 of this Strategy. Once additional independent NHS dental contractors are listed and working in Shetland, there will be a reducing need for the local population to be registered with the PDS under its safety-net role, and the Board can take the

opportunity to position the PDS towards the more specialised role as expected by the Scottish Government, providing the Level 2 and Level 3 care in the patient pathway between Level 1 primary care dentistry and the Level 4 consultant-led secondary and tertiary care.

The PDS has already been fulfilling this role to an extent, but has been unable to develop it more formally while being dominated by fulfilling its safety-net role. It is currently fulfilling it in part by receiving and processing clinical referrals from the local dental practice, assessing their complexity, providing the care it is competent and able to, and forwarding more complex clinical care to consultant-led services when appropriate.

The local population requires access to the dental specialities of Special Care Dentistry, Paediatric Dentistry, oral surgery, orthodontics, and restorative dentistry, the majority of which can be provided on-island.

Because of the quantity of work available within Shetland, the PDS will therefore look to employing two Specialists in Special Care Dentistry, one specialist in orthodontics and one part-time specialist in oral surgery. It will also seek to develop dentists with special interests in paediatric dentistry and restorative dentistry who would be able to carry out the majority of work in these specialities, linking in with Grampian for overall consultant oversight.

For maxillo-facial surgery and the small amount of orthodontics that requires multi-disciplinary working, the current arrangement of visiting consultants from Grampian would continue.

13.6 Review orthodontic provision in Shetland to substantially improve access, and to reduce the risk of service failure.

With most orthodontic provision in Shetland dependent on one visiting consultant from Grampian and one locum consultant from further south, there is considerable scope for a service redesign to use the current resources more effectively and efficiently.

13.7 Encourage the establishment of Dental Technical Laboratory in Shetland

The overwhelming majority of all dental technical work is sent by post off-island to dental laboratories elsewhere in the UK, delaying the provision of dentures, crowns, bridges, orthodontic appliances etc. It is estimated that there would be sufficient work for a resident full-time dental technician in Shetland, which would speed up dental treatment and would be popular with Shetland-based clinicians. Such a business development would provide local employment, and perhaps be a base for training further technicians. It could receive work from off-island too. If the technician was registered as a Clinical Dental Technician he/she could carry out denture construction for patients from start to finish, thus releasing local dentists for other clinical priorities.

It is anticipated that these Issues will be developed further with Action Plans for each, once two significant factors are made public:

- The expected announcement from Scottish Government with details of a revised dental contract
- The publication of possible further developments to the provision of independent NHS dentistry in Shetland.

It is anticipated that both these will assist in the further development of oral health care services in Shetland that will help to meet the Vision of Oral Health for All.

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Glossary

Caring for Smiles: A Scottish oral health promotion initiative aimed at improving the oral health of people in Care Homes through an education programme for carers.

Childsmile: A Scottish national programme funded by Scottish Government designed to improve the oral health of children and reduce inequalities both in dental health and access to dental services. There are five components, Childsmile Practice, Childsmile Core brushing, Childsmile Nursery, Childsmile School, and the Childsmile Dental Health Surveillance & Protection Framework.

Dental caries: The material remaining after tooth substance has been destroyed as a result of attack by acids produced by plaque bacteria from sugars in the diet. It is commonly referred to as 'tooth decay'.

Dental trauma: Tooth loss or damage caused by physical injury.

Dentate: Presence of some or all natural teeth.

DMFT/dmft: An indicator of the level of dental decay obtained by adding the number of decayed, missing and filled teeth into a composite total score, the DMFT index for the permanent dentition and the dmft index for the primary dentition. The mean score is generally reported for a population.

Edentulousness / Edentate: State in which all natural teeth have been lost.

General (Endotracheal) anaesthesia: Inhalation anaesthesia technique in which anaesthetic and respiratory gases pass through a tube placed in the trachea via the mouth or nose.

Evidence-based practice: The conscientious, explicit and judicious use of current best practice.

Fluoride: Chemical compounds that help to prevent the onset of dental caries by reducing the solubility of dental enamel in ingested acids. Fluoride is an active ingredient in most toothpastes, and may be added to drinking water, or to milk or table salt.

Functional dentition: Twenty teeth are considered to be the minimum number of teeth needed to maintain a functional dentition.

Gingivitis: Inflammation of the gum margins adjacent to the teeth, demonstrated by bleeding on brushing.

Malocclusion: A misalignment between the occlusion of the upper and lower teeth and jaws, which may need orthodontic treatment.

Oral cancer: Malignant tumours arising from any part of the mouth, including tongue, cheek, gums, glands and jaws. Only 1% of oral cancers arise from the jaw bones themselves. Alcohol and tobacco use account for 90% of all oral cancers.

Oral health: A standard of health of the oral and related tissues which enables an individual to eat, speak and socialise without active disease, discomfort or embarrassment and which contributes to general well-being (Department of Health, 1994).

Orthodontics: The dental specialty concerned with facial growth, the development of the dentition and occlusion, and the assessment, diagnosis, interception and treatment of malocclusions and facial irregularities.

Periodontal disease/ Periodontitis: A range of disease of the gums and supporting structures of the teeth. It is commonly referred to as ‘gum disease.’

Permanent dentition: The adult dentition / teeth.

Pocketing: In the early stages of periodontal disease pockets form as the gums separate from the teeth. The tissue that anchors the teeth to bone becomes inflamed and there is slight bone loss around the teeth. As the disease progresses, pocketing may become deeper as bone loss progresses, or the gums may recede down the root of the tooth.

Primary (Deciduous) dentition: First dentition, commonly referred to as ‘baby’ teeth or milk teeth, which are later exfoliated and replaced by adult teeth (the secondary dentition.)

Water fluoridation: The addition of fluoride to local water supplies to bring the level of natural fluoride already in the water up to the optimum level (1 part per million) which reduces tooth decay in the local population by 30 – 50%.

Rapid Impact Checklist - An Equality and Diversity Checklist

Which groups in the population do you think will be affected by this Strategy?	All members of the population: Men & Women of all ages Children & young people People with all protected characteristics People of all incomes Homeless people Staff Permanent residents Temporary residents Visitors and tourists

What impact will the Strategy have on lifestyles?	Increased oral health Reduced morbidity Decreased pain and sepsis Reduction in time off from employment and education due to tooth-related

	problems Positive impact on Diet and Nutrition Encourage smoking cessation Increase knowledge in the population Encourage healthy lifestyles Reduce obesity and diabetes Reduce risk-taking behaviour Increase personal choice
What impact will the Strategy have on the Social Environment?	Will enhance social well-being through increased self-esteem Will increase the local work-force Will decrease absenteeism through ill health Will reduce health-related stress
What impact will the Strategy have on the physical environment?	Should reduce patient travel to/from distant service locations
Will the Strategy have any impact on the following? **Discrimination** **Equality of opportunity** **Relations between population groups**	The Strategy should alleviate the current discrimination between those with NHS dental registrations and those who do not, providing equality of opportunity. It should alleviate the differences in service provision for those who are permanent residents and those who are not.
What impact will the Strategy have on access to and experience of services?	Will overcome current two-tier service access . Will increase patient-centred approach to service provision. Will increase patient satisfaction.

Agenda Item

7

Meeting:	Integration Joint Board
Date:	28 June 2016
Report Title:	Draft Hospital Based Complex Clinical Care Policy
Reference Number:	CC-45-16 F
Author / Job Title:	Kathleen Carolan, Director of Nursing & Acute Services Simon Bokor Ingram, Director of Community Health & Social Care Roger Diggle, Medical Director

Decisions / Action required:

The IJB is asked to note the process of joint policy development and approve the policy so that it can be fully implemented across Health and Social Care Services in Shetland.

High Level Summary:

This policy sets out the practical interpretation of the guidance included in DL (2015) and the process of assessing HBCCC and managing any disputes that may arise. The policy also includes key information that should be given to patients who are being assessed to better understand their ongoing care requirements and the most appropriate setting in which that long term clinical care can (and should be delivered).

Corporate Priorities and Strategic Aims:

- To improve and protect the health of the people of Shetland
- To provide quality, effective and safe services, delivered in the most appropriate setting for the patient
- To provide best value for resources and deliver financial balance
- To ensure sufficient organisational capacity, capability and resilience

Key Issues:

The policy has been developed using DL (2015) 11 guidance with local adaptations to fit the local context of service delivery. The policy has been developed jointly by Health and Social Care services through the Joint Health and Social Care Management Team, which is co-chaired by the Director of Nursing and Acute Services and the Director of Community Health and Social Care.

It has been agreed that an enhanced level of information about discharge planning arrangements should be provided to all patients and the leaflet included in the policy will form part of the hospital information pack. However, the specific assessment processes and discussions about the need for HBCCC will only be initiated if a patient has complex needs and the position is not already extant that the ongoing healthcare requirements cannot be met in the community setting.

Implications :	
Service Users, Patients and Communities:	The policy implementation will include awareness raising, information materials to guide decision making and clear processes so that patients, carers and families understand the purpose of the policy and how it will be used to determine the setting in which complex care will be delivered (which is mostly likely to be in the community, but for highly specialised complex care requirements that may be a specialist facility out with Shetland)
Human Resources and Organisational Development:	The policy will need a communication plan to ensure that staff are aware of the changes to the status and assessment of ongoing complex clinical care needs.
Equality, Diversity and Human Rights:	The policy applies to children and adults and seeks to provide a consistent approach to the assessment of HBCCC requirements. The scope of the policy does not include other services that could be delivered in the community where there isn't already a service in place.
Partnership Working	The policy requires close collaboration (in its implementation) to ensure that complex clinical care is delivered in an appropriate setting to meet the healthcare needs of individuals
Legal:	The policy sets out the arrangements for managing patient disputes and appeals. The Board may take exceptional cases to the court for enforcement of the proposed discharge arrangements
Finance:	There are no financial implications arising directly for the implementation of this policy. Any expenditure will be met from existing IJB budgets.
Assets and Property:	There are no implications for major assets and property.
Environmental:	There are no environmental issues arising from this report.
Risk Management:	
Policy and Delegated Authority:	Shetland's Integration Joint Board has delegated authority to determine matters relating to those services for which it has responsibly and oversight for, as set out in the Integration Scheme and the IJB Scheme of Administration [2015]. In exercising its functions the IJB must take into account the requirement to meet statutory obligations placed on the NHS and SIC, including those that pertain to delegated IJB functions.
Previously considered by:	The proposals in this report have been presented at the Joint Health & Social Care Management Team in January 2016 and considered an earlier version in October 2015

Shetland Islands Council

NHS Shetland

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1. Introduction

1.1 The purpose of this report is to ask the IJB to note the process of joint policy development and APPROVE the policy so that it can be fully implemented across Health and Social Care Services in Shetland. See Appendix 1.

2. Background

2.1 DL (2015) 11 provides guidance on the responsibility of NHS Scotland for providing Hospital Based Complex Clinical Care (HBCCC) and replaces CEL 6 (2008). DL (2015) 11, became effective on 1/6/2015 and replaces all previous guidance on NHS Continuing Care. People who are already assessed as eligible for continuing care are not affected by these changes to policy.

2.2 The aim of this new guidance is to make the clinical decision more transparent with the primary eligibility question simply being **"can this individual's care needs be properly met in any setting other than a hospital?"** The outcome of this question needs to be discussed, documented and explained fully with individuals, families and carers.

2.3 For some individuals across Scotland, Hospital Based Complex Clinical Care will be required and this may mean a longer stay in hospital. The key aim for anyone that does need to be in hospital for a longer period of time is to get them well enough to return to whatever setting is most suitable for them in the community while ensuring that all health or social care needs are supported.

2.4 The draft policy has also been shared with the Public Participation Forum (PPF) to ensure that there has been an opportunity for patients, carers and families to also comment on the process.

3. Conclusions

3.1 The Policy will provide detailed advice in which complex care will be delivered and which is most likely to be in the community, but for highly specialised complex care requirements, may be a specialist facility outwith Shetland.

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6 June 2016

Appendices
Appendix 1 – Draft Hospital Based Complex Clinical Care

NHS Shetland &
Shetland Islands Council

Hospital Based Complex Clinical Care

If you would like this document in an alternative language or format, please contact Corporate Services at 01595 743000 (via Switch)

Document Development Coversheet

Date: January 2016

Version Number: 2

Author: Kathleen Carolan

Date of Approval: (initial version)

Review Date: January 2018

Name of Document	**Hospital Based Complex Care**	
Registration Reference Number		**Document Type** **New**
Author	**Kathleen Carolan, Director of Nursing & Acute Services**	
Executive Lead	**Roger Diggle, Medical Director**	

Proposed Groups to Present Document to:	
Joint Health & Care Strategic Group	**PFPI Steering Group**
Strategy & Redesign Committee	
Integrated Joint Board	

Date	**Version**	**Group**	**Reason**	**Outcome**
09/15	1	JH&CSG	Initial draft	Some duplicate content removed regarding the assessment of capacity Request for consistency in the use of Care Co-ordinator rather than Social Worker Process flow chart added Patient leaflets added Examples of assessment documentation added Detailed information about resolving disputes has been added
01/16	2	JH&CSG	Penultimate draft	

Reasons for Presenting to the Group	**Outcomes Following Meeting**
As above	**As above**

Please record details of any changes made to the document on the back of this form.

Date	Changes Made to the Document
01/2016 **(to first draft)**	Some duplicate content removed regarding the assessment of capacity Request for consistency in the use of Care Co-ordinator rather than Social Worker Process flow chart added Patient leaflets added Examples of assessment documentation added Detailed information about resolving disputes has been added
02/2016 **(to second draft)**	Some duplicate content removed regarding the assessment of capacity Clarification that the second opinion is part of the 'appeals process' Clarification that HBCCC will not form part of routine multi-disciplinary team discussions and will only be prompted if it is thought that ongoing healthcare requirements might not be manageable in a community setting (within the existing range of services)

Thanks and acknowledgements to NHS Fife and NHS Borders for sharing materials which have been adapted and incorporated into this policy document.

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1. Introduction & context

What is Hospital Based Complex Clinical Care?

Anyone can be assessed for eligibility for Hospital Based Complex Clinical Care (HBCCC) – care that can only be provided in hospital. It does not depend on your age, or having a particular disease, diagnosis or condition. The key aim for everyone is to ensure that as soon as the person no longer requires to be in hospital that they are supported to return to whatever community setting is most suitable for them, whilst ensuring all their health or social care needs are supported. If the person is not suitable to be discharged they may be assessed for hospital based complex care.

Aim of the policy

This guidance is based on the recommendations from the independent review and covers the responsibilities of the NHS in Scotland for providing Hospital Based Complex Clinical Care to the population. It replaces previous guidance contained in CEL 6 (2008).

The detail is taken from DL (2015)11[1]and has been adapted for the local context.

On 2 May 2014 the *Independent Review of NHS Continuing Healthcare*[2] was published. The then Cabinet Secretary for Health and Wellbeing accepted all nine recommendations with the key recommendation to replace NHS Continuing Healthcare CEL 6 (2008)[3] which the review established was no longer fit for purpose.

The aim of this new guidance is to make the clinical decision more transparent with the primary eligibility question simply being **"can this individual's care needs be properly met in any setting other than a hospital?"** The outcome of this question needs to be discussed, documented and explained fully with individuals, families and carers.

For some individuals across Scotland, Hospital Based Complex Clinical Care will be required and this may mean a longer stay in hospital. The key aim for anyone that does need to be in hospital for a longer period of time is to get them well enough to return to whatever setting is most suitable for them in the community while ensuring that all health or social care needs are supported.

The overall objectives of the new guidance are to:

- Promote a consistent basis for the provision of Hospital Based Complex Clinical Care.

[1] http://www.sehd.scot.nhs.uk/dl/DL(2015)11.pdf

[2] Independent Review in NHS Continuing Healthcare – 2 May 2014

[3] NHS Continuing Healthcare CEL 6 2008 – 7 February 2008

- Provide simplification and transparency to the current system;
- Maintain clinical decision making as part of a multi-disciplinary process;
- Ensure entitlement is based on the main eligibility question **"can this individual's care needs be properly met in any setting other than a hospital?"**
- Ensure a formal record is kept of each step of the decision process.
- Ensure that patients, their families and their carers have access to relevant and understandable information (particularly if the individual does not need to be in hospital but rather an alternative setting in the community).

2. Guiding principles

This guidance is not merely a clarification of the NHS Continuing Healthcare policy that has been in place – rather, it is a fundamental reform of how we support people who have on-going clinical needs. This guidance seeks to abide by a number of core principles:

- As far as possible, hospitals should not be places where people live – even for people with on-going clinical needs. They are places to go for people who need specialist short-term or episodic care. Hospitals are highly complex institutions which should focus on improving the health of people with acute conditions before discharging them back into the community.
- The NHS in Scotland has a duty to provide healthcare. In a hospital setting, in order to fulfil that duty, the NHS will provide food and accommodation. However, when someone is living in the community, it is not the role of the NHS to pay for accommodation and living costs – other arrangements and support mechanisms are in place for that. Financial support for living costs should be considered on the basis of ability to pay, rather than through a clinical needs assessment.

Consideration of capacity and the principles and requirements of the Adults with Incapacity (Scotland) Act 2000, Human Rights, and Equality legislation must underpin the application of this guidance.

The issue of the patient's capacity to make informed decisions about future care should be investigated as early as possible in the patient's journey. This will help to avoid unnecessary delays in assessing care needs and the discharge planning process.

Scope of the policy – who will this guidance affect?

This policy is applicable equally to individuals of all ages with any illness or disability.

3. Discharge planning process

Wherever possible **Discharge planning** will have commenced on, or soon after, admission in partnership with the patient and their family or proxy. The leaflet ***Ready for Discharge, What Happens Next?*** will be given to the patient, family or proxy at an early stage by the nursing team. The Leaflet is included in patient information admission packs – it is also shown as Appendix D.

When it is agreed by the **Consultant** and the **multi-disciplinary team (MDT)** that the patient is clinically fit for discharge the responsible **Consultant** will advise the patient, family or proxy that the patient no longer requires hospital care, and that further assessments will be carried out by the MDT to determine what future care arrangements are required.

The patient, family or proxy will be advised of the **estimated date of discharge** as soon as practically possible, and advised that the expectation is that discharge arrangements will be in place for that date.

If the assessment of the patient concludes that that the patient's needs and abilities prevent them from returning home, it is essential that the MDT have considered and documented that:

- All other long term care options have been explored including the potential to support needs with care (including equipment and adaptations) at home, or in another community setting;
- The potential for reablement and/or rehabilitation has been fully explored;
- The patient, family or the proxy have been fully involved throughout the process.

As part of the MDT assessment the Consultant should consider eligibility for **Hospital Based Complex Clinical Care** if the patient requires ongoing, specialist healthcare so that through the assessment process; the type of specialist healthcare input can be determined along with the identification of the most appropriate setting in which the healthcare should be delivered. The assessment to determine HBCCC requirements will only take place is specialist healthcare input is necessary.

4. Assessing eligibility for hospital based complex clinical care

The eligibility/entitlement has now been simplified and will be down to one primary question, **"can this individual's care needs be properly met in any setting other than a hospital?"** The decision making process is summarised in Appendix A**.**

The response to the eligibility question will be decided by the responsible consultant or equivalent specialist informed by the Multi-Disciplinary Team (MDT). Appendix C provides some suggested documentation for recording the outcome of the MDT discussion in relation to the patients complex clinical care needs status.

The MDT assessments are crucial in establishing the best place for an individual patient to have their clinical healthcare needs met. All options should be considered and the outcome of the process explained to the individual, their family and carer.

5. The appeals process

If the person does not agree with the outcome of the assessment, they are entitled to a second opinion, in line with current medical practice. However, when a final decision has been reached that the person is clinically ready for discharge there should be no delay. No individual has the right to choose to remain in hospital when there is no longer a need for inpatient care.

If a patient wishes to appeal the clinical decision concerning eligibility for ongoing hospital based complex clinical care, then they must write to their doctor within 10 days of receiving the decision to discharge to lodge an appeal. A leaflet setting out the definition of HBCCC and the appeals process is shown in Appendix E.

It is essential that medical, nursing and social care staff spend time with the patient, family or proxy to discuss discharge and post-discharge issues in an open and sensitive manner, but if there is a dispute regarding the discharge plan (either as a result of disagreements concerning the complex clinical care status of the patient or choice of residential options) then information about the discharge process will be provided to the patient, family or proxy. This should be written in plain language, and in a format appropriate to the patient, and should clearly explain:

- Admission, transfer and discharge policies
- Why remaining in hospital is not an option
- The need to make **realistic** choices from **suitable, available** care facilities
- Procedures for interim moves, if a home of choice is not available
- Any costs to the individual.
- The NHS and local authority complaints procedures

6. **Roles and responsibilities**

Patients, family members and proxies

The patient, family or proxy should participate fully in discussions with health and social care professionals regarding the patient's future care needs. The opportunity to participate in discussions about assessed care needs include Case Conferences and Multi-professional meetings – where goals are agreed with the patient, including plans for care following discharge.

All Professionals

All staff involved in the patient's care should give a clear and consistent message concerning the discharge planning process and ongoing care provision in the community.

The Consultant/GP

It is not the role of the doctor alone to make decisions regarding the next stage of the patients care (i.e. whether or not the patient will need to go home, or to a care home). These decisions are best made following a thorough assessment process, involving health, social care and other relevant agencies. Once it has been established that a patients' ongoing needs can be met in a setting other than a hospital; the Hospital Liaison Social Worker will take the lead on ensuring that the social care needs assessment is completed and the outcome is relayed to the MDT.

The doctor will support all decisions regarding the next stage of care made by the social work team, and other relevant agencies and should not agree to patients remaining in hospital purely to wait for their preferred choice of care home to become available.

The doctor will be informed of any problem discharges by the Charge Nurse, as appropriate. Where resolution cannot be attained with the support of the doctor the case should be referred immediately to the Medical Director.

Senior Charge Nurse & Ward Staff

The Senior Charge Nurse will work with the nursing staff to ensure there is effective and inclusive communication with patient, family or proxy throughout the discharge planning process. And ensure that patients, families and carers have a positive experience during the hospital stay

It is not the role of nursing staff alone to decide on the next stage of care for the patient out with the hospital setting. The care needs assessment process will be led by the **Social Worker or Care Co-ordinator**, involving healthcare professionals, and other agencies as appropriate to determine the ongoing social care requirements. The nurses along with the wider MDT will contribute to this process and ensure that the ongoing clinical care requirements for are clearly defined.

In cases where the patient, family or proxy continue to refuse to actively engage with the discharge planning process or refuse to leave the hospital on the agreed discharge date (following appropriate MDT assessment of the patients health and social care needs); the Senior Charge Nurse will escalate cases to the Medical Director for action. This should be done through the doctor in charge of the patients overall care in hospital.

Social Work / Social Care Staff

The Care Co-ordinator[4] will have the lead responsibility for the assessment of social care needs and provision of social care services on discharge from hospital. They also have lead responsibility for convening and chairing meetings with the patient, family and/or proxy to discuss future care arrangements.

The Care Co-ordinator should ensure that the social care planning process is started as early as possible in the patient's journey; always ensuring that any possibility of the patient returning home, with support is explored first. The health and care needs assessments should be carried out jointly by health and social care staff, and should fully involve the patient, family (where the patient agrees) or proxy from the outset. Results from the assessment should be communicated to the patient, family or proxy in an appropriate format.

The Care Co-ordinator is responsible for ensuring that a financial assessment is offered and discussing likely costs of care with the patient, family or proxy.

Medical Director

Once informed by the Consultant, the Medical Director will write to the patient, family or proxy explaining that they do not meet the eligibility criteria for hospital based complex

[4] This could be a Social Worker or Senior Social Care Worker

clinical care and that a discharge date has been set and a care package/placement identified.

If the patient appeals the decision that they are not eligible for hospital based complex clinical care, then the Medical Director will organise for a medical 'second opinion'. If the second opinion upholds the original medical assessment, then the patient will be informed of the outcome and that we will proceed with discharge planning arrangements.

The decision of the Medical Director is final and there is no further right of appeal, however, if the person/family/carer is concerned that due process has not been followed then this can be raised with the **NHS Shetland Complaints Officer.**

Where the patient, family or proxies continue to unreasonably refuse to engage with the choice and/or discharge process a Health Board can choose, as a last resort, to seek enforcement of the discharge through the courts.

7. **Training**

Health care teams

Senior nurses (e.g. Team Leaders and SCNs) will manage and develop the nursing teams knowledge and experience in discharge planning through appropriate regular training, to ensure the best quality care, information and advice is provided at all times.

Partner organisations will ensure that all staff who are required to utilise this policy guidance will receive appropriate training to:

- Undertake discharge planning activities
- Participate in multi-disciplinary clinical and care assessments
- Signpost patients to information about discharge planning and the assessment of hospital based complex clinical care needs

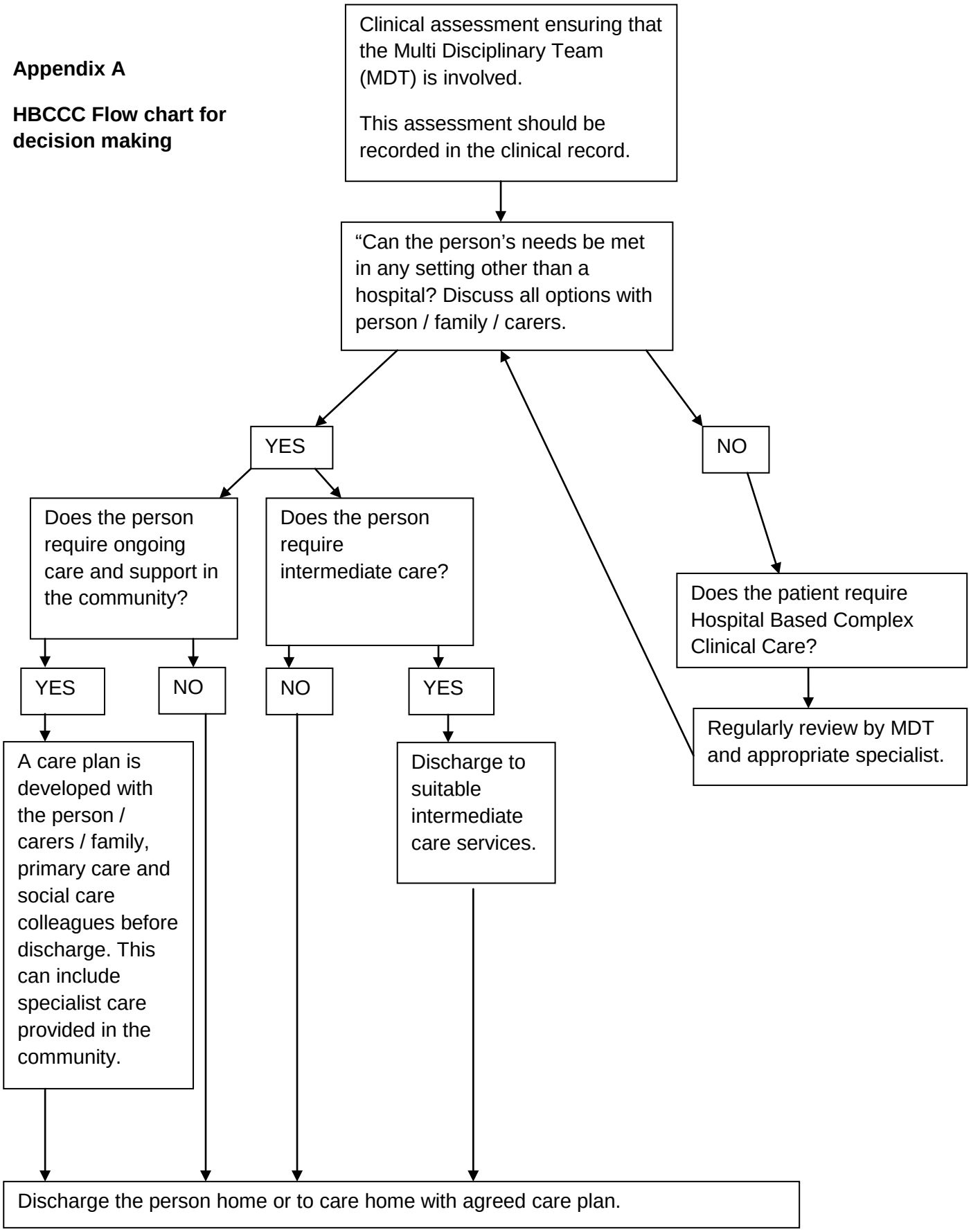
8. **Audit and performance monitoring**

There are a number of ways in which the policy implementation will be reviewed:

- An annual audit of the Key Performance Indicators (KPIs) associated with this policy area
- Weekly review of patients delayed in hospital who are medically fit and the circumstances around the reasons for delay
- Quarterly review of all patient delays at the Joint Health & Care Strategic Group (multi-agency, professional forum)

Appendix A

HBCCC Flow chart for decision making



1. Communication – with MDT, patients, families and carers throughout the process.
2. Record keeping – Every decision that is made from the clinical assessment should be recorded in the clinical record.
3. Disagreement – if there is any disagreement then a second option can be requested at each decision point. If there is still no agreement after the second opinion then a letter is sent to the Medical Director for final resolution.

Appendix B

Process for appeals against discharge from Hospital Based Complex Clinical Care (HBCCC)

Background

DL (2015) 11 provides guidance on the responsibility of NHS Scotland for providing Hospital Based Complex Clinical Care (HBCCC) and replaces CEL 6 (2008).

DL (2015) became effective on 1/6/2015.

The DL states the principle that 'No individual has a right to choose to remain in hospital when there is no longer a need for in-patient care.

Situation

The eligibility / entitlement has now been simplified to one primary question **'can this individual's care needs be properly met in any setting other than hospital'**

The response to this question should be decided by the responsible consultant or equivalent specialist and this decision should be informed by a comprehensive multidisciplinary team assessment.

The assessment and decision should be clearly recorded in the patient's case records.

It is expected that through this decision making process there will be good, clear, documented communication with the patient, family and carers, wherever possible.

From time to time there maybe disagreements between professionals or between professionals and the patient, family or carer.

The disagreement maybe by the patient, the power of attorney, or another professional involved in the care of the individual.

The resolution of disagreements is the responsibility of the NHS Shetland Board Medical Director or deputy.

Procedure

The person who is disagreeing with the decision of the responsible consultant should set out in writing, within 10 days of the decision to discharge the reasons why 'the individual's care needs **cannot** be properly met in any setting other than hospital'.

The medical director should ask the responsible consultant to provide within 7 days

Evidence of the multidisciplinary assessment
Evidence of the communication with the patient, family or carers
A response to the concerns of the party disagreeing with the decision

The Medical Director will reach a decision on the evidence provided by the disagreeing party, the consultant responsible and any other investigations that he or she sees to be appropriate.

The Medical Director may take advice from others as he/she sees fit.

The Medical Director's decision is final.

The Medical Director will communicate his/her decision in writing to the responsible consultant and the complainant within 7 days of reaching a decision.

Appendix C – example of the documentation required to evidence that a complex care assessment has taken place

Case Conference/Multi-disciplinary Meeting - Complex Care Assessment

PATIENT'S NAME:		**WARD:**	
CHI No:		**DATE OF BIRTH:**	
DATE OF MEETING:			

PRESENT	DESIGNATION
	Occupational Therapist
	Physiotherapist
	Nurse
	Next of kin
	Medical staff
	Outside agencies
	Other
	Other
	Other
	Other
	Other

REASON FOR CASE CONFERENCE

MAIN POINTS DISCUSSED	
1	
2	
3	
4	

5	

MAIN POINTS DISCUSSED (Continued)	
6	
7	
8	
9	
10	

RECOMMENDATIONS

ACTION	RESPONSIBLE	DATE DUE	COMMENTS

DISCHARGE DATE	SIGNATURE	DATE

COPIES HELD/DISTRIBUTED TO	
❑ Medical notes	❑ Social worker
❑ Nursing notes	❑ Occupational Therapist
❑ Occupational therapist	❑ Home Care Manager
❑ Physiotherapist	❑ District Nurse
❑ Other (Please state)	❑ Other (Please state)

Complex care assessment outcome (suggested entry in the notes)

Can this patient's needs be met in other setting? Yes No

Date

Next review date

Signature

Print

Ready for discharge?
What happens next?

A guide for patients, families and carers

What is discharge planning?

Discharge planning is a process that helps to identify the services and support you may need when you leave hospital. Planning will start on, or soon after your admission to hospital.
The planning process will help to ensure that appropriate support is available in the community to help you when you leave hospital.

How are my needs assessed?

The discharge plan will be developed following an assessment of your needs by health and social care staff—this is called a **multi-disciplinary assessment**. As part of the assessment process you may be transferred to another NHS facility, or even your own home or a care home, for further assessment or rehabilitation. This is to ensure that you are given the best opportunity to recover and return permanently to your own home with support if needed.

The multi-disciplinary team may consist of a range of different professionals including:

Hospital Doctor	Hospital pharmacist	Physiotherapist
Nursing Staff	Dietitian	Social care staff
Discharge co-ordinator	Occupational Therapist	Community care worker

Why can't I stay in hospital?

You were admitted to hospital for specific medical care and treatment. These treatments are now concluded and your doctor has assessed that you are fit to be discharged. Staying in hospital any longer is not in your best interests and could actually be detrimental to your health and independence.

Your right to appeal

If you do not think you are ready for discharge you have the right to appeal this decision. You can also ask an advocate, relative or carer to appeal on your behalf. It is important to understand that you are appealing against your doctor's clinical decision to discharge you. This is not an appeal on the outcome of your assessment.

If you wish to appeal, you have 10 working days from the date you were informed of the decision to discharge to write a letter of appeal to your doctor. If you need help writing a letter please ask your nurse, family, carer, relative or Patient's Advice and Support Service (PAAS) for help.

NHS Complaints Procedure

If you are unhappy with the outcome of your appeal you can then make a complaint through the formal NHS complaints procedure. However, you should be aware that **this is not a route for appeals against clinical decisions**. The complaints procedure will consider the process by which decisions were reached and may conclude that the process was flawed and should re-run.

Complaints must be made within 6 months of the decision being given to you, or within 6 months of realising you have a reason to complain (but no longer than 12 months after the event).

Advocacy & support services

If you find it difficult to express your views or feel that your voice is not being heard, then you might need an independent advocate. Independent Advocacy can support you to express your choice regarding health treatment and your future care needs. You can find out about Independent Advocacy in your area from social care staff, or by contacting the Scottish independent Advocacy Alliance (see useful contacts).

The **Patient's Advice & Support Service (PASS)** (provided by the Citizens Advice Bureaux) gives free independent advice on the rights and responsibilities of patients. It also advises and supports people who wish to comment or complain about treatment and care provided by the NHS in Scotland.

Who pays for my care?

NHS services are provided free of charge. This includes NHS services provided by GP practices, local pharmacies, hospitals or clinics and emergency services.

Your local authority may charge you for providing some services. When you have an assessment of your care needs, you will be given details of any charges that may apply to services you are assessed as needing.

Financial Assessments

The social work service will work out how much you can afford to contribute towards the 'hotel' or 'accommodation' costs of the care home by assessing your income, including pensions and social security benefits and any capital you have, including savings, investments or property. If you disagree with the amount you are asked to pay, you can ask for a review.

If you prefer not to have a financial assessment you can refuse, but you will have to pay the full cost of any services arranged for you. No matter who your provider is, you should be told what their service will include and how much it will cost before the service begins.

The Self-directed Support (Scotland) Act 2013 places duties on the Local Authority to ensure that you are given four different options for how your support is provided. You can choose to have lots of control over your care and support or you can leave most of the decisions and work to the local authority or you can have a mix. More information on this will be provided during your assessment along with support to help you decide which option best suits you.

NHS Continuing Healthcare

NHS Continuing Healthcare is for people with very complex care needs that can only be met under the supervision of specialist healthcare professionals. A clinical assessment is needed to determine eligibility, your doctor will advise whether this is necessary. An information leaflet will also be available.

Free Personal and Nursing Care

Free **personal care** is available for everyone aged 65 and over in Scotland assessed by the local authority as needing it. Free **nursing care** is available for people of any age assessed as requiring nursing care services. If you are assessed as needing personal and nursing care you will receive this regardless of income or capital assets. However, if you require care in a care home you will need to contribute towards your remaining hotel and accommodation costs.

Useful contacts

Scottish Independent Advocacy Alliance

Helps people express their needs and make their own decisions

www.siaa.org.uk

0131 260 5380

Patient's Advice and Support Service

www.patientadvicescotland.org.uk

Your local telephone book will have contact details for your local citizens advice bureau.

Care Information Scotland

CIS is a telephone and website service providing information about care services for older people living in Scotland.

www.careinfoscotland.co.uk

08456 001 001

What is Hospital Based Complex Clinical Care (HBCCC)? Patient Information

For a copy of this information in

- **large print**
- **another language**
- **audiotape**
- **Braille**

Telephone: 01595 743060

What is Hospital Based Complex Clinical Care?

Anyone can be assessed for eligibility for Hospital Based Complex Care – care that can only be provided in hospital. It does not depend on your age, or having a particular disease, diagnosis or condition. The key aim for everyone is to ensure that as soon as the person no longer requires to be in hospital that they are supported to return to whatever community setting is most suitable for them, whilst ensuring all their health or social care needs are supported. If the person is not suitable to be discharged they may be assessed for hospital based complex care.

In Scotland, the NHS has a legal duty to provide healthcare, however, when someone is living in the community it is not the role of the NHS to pay for accommodation and living costs. Financial support for living costs should be considered on the basis of ability to pay, rather than through a clinical needs assessment.

How does Hospital Based Complex Clinical Care affect me?

The primary question doctors, nurses and allied health professionals will ask about a person will be **"can this individual's care needs be properly met in any setting other than a hospital?"**

The response to this eligibility question will be agreed by the consultant responsible for a person's care, or equivalent specialist. This opinion will be informed by the Multi-Disciplinary Team consisting of nurses, allied health professionals e.g. physiotherapist, occupational therapist, social workers and anyone else directly involved in the care of the person. This will establish the best place for the person to have their clinical healthcare needs met. All options should be considered and the outcome of the process explained to the person, their family and carer.

A range of options and decisions can be considered:

- The person's needs cannot be met in any other setting other than a hospital. Then the person will remain in hospital and will be regularly reviewed by the Multi-Disciplinary Team.

- The person's needs can be met in a setting other than a hospital.
    - The next question is "does the person require intermediate care?" (Intermediate Care is where the person does not require care within the hospital, but is not at a stage where they are able to return to where they were before their hospital admission).
    - If yes, the person will be discharged to a suitable Intermediate Care Service (for example a bed in the community in a care home for Intermediate Care and Rehabilitation).
    - If no, the person will be discharged to their home or to a care home with an agreed care plan.
    - If the person requires ongoing care and support in the community then a care plan is developed with the person, carers, families, primary care and social care before discharge. This can include specialist care provided in the community.

If, following a period of intermediate care, the specialist Multidisciplinary Team, in consultation with the person, family or carer, consider that the person requires long term care and support that cannot be provided at home or in alternative housing, the person will be moved to a care home as noted in the Guidance on Choosing a Care Home from Hospital (http://www.sehd.scot.nhs.uk/mels/CEL2013_32.pdf). In that situation, accommodation and non-healthcare costs will be liable to charging dependent on the person's financial circumstances. The link to information on charging can be found at http://www.gov.scot/Topics/Health/Support-Social-Care/Support/Older-People/Free-Personal-Nursing-Care

All discussions regarding the person's care needs will be recorded in their notes. The person, families and their carers will be involved throughout the discharge process and all options and decisions fully explained.

What if you don't agree with the decision?

The person, carer or family is entitled to a second opinion, in line with current medical practice. However, when a final decision has been reached that the person is clinically ready for discharge there should be no delay. No individual has the right to choose to remain in hospital when there is no longer a need for inpatient care.

What if there remains a disagreement?

If there remains a disagreement between professionals, or between professionals and the person/family/carer, or between health and social care professionals as to the ongoing care needs then within 10 days of the patient being informed the dispute should go to the Medical Director for final resolution. The Medical Director's contact details are:

Medical Director

NHS Shetland Board Headquarters

Upper Floor

Montfield

Burgh Road

Lerwick

ZE1 0LA

Tel: 01595 743060

The decision of the Medical Director is final and there is no further right of appeal, however, if the person/family/carer is concerned that due process has not been followed then this can be raised with the **NHS Shetland Complaints Officer.**

NHS Shetland Complaints Officer
NHS Shetland Board Headquarters

Tel: 01595 743060

Leaflets explaining the complaints procedure are available on request.

Where can you get independent help and advice?

For free advice about any treatment you have received from the NHS, please contact the Citizens Advice Bureau. They will help with information on your rights to NHS services, raising concerns and resolving issues and advocacy. They will also help you with NHS complaints procedures should you have a concern.

If you are not satisfied
If, after all the appeals and complaints steps, you are still not satisfied with the process you can contact:

The Scottish Public Services Ombudsman
4 Melville Street
Edinburgh
EH3 7NS

Telephone: 0800 377 7330
Email: ask@spso.org.uk

Agenda Item

8

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	28 June 2016
Report Title:	Shetland Alcohol and Drugs Partnership (SADP) Governance and Terms of Reference Covering Report
Report Number:	CRP-14-16-F
Author / Job Title:	Christine Ferguson, Director Corporate Services

Decisions / Action required:

1. The IJB is asked to:
   a) consider the information presented in this report, the main report attached and its appendices; and
   b) recommend the revised Terms of Reference (TOR) for SADP to the Council and the Health Board for approval.

High Level Summary:

This report presents information and proposals regarding the governance arrangements of SADP and seeks agreement of the IJB for the revised TOR attached at Appendix 3 to the main report and a recommendation to the Council and the Health Board to approve the TOR.

The TOR have been updated to take account of the role of the IJB in commissioning health and social care services for alcohol and drug misuse.

Corporate Priorities and Joint Working:

The work of SADP contributes to the priorities in Shetland's Local Outcome Improvement Plan 2016, in particular "*Ensuring the needs of our most vulnerable children and young people are met*" and "*Reduce the harm caused by alcohol*".

SADP brings together NHS, Council, Police and Fire and Rescue colleagues in partnership recognising the necessity for partnership working across these agencies in order to tackle the multi-faceted nature of the issues that can arise from substance misuse for individuals, their families and the community.

SADP supports the work of the Shetland (Community Planning) Partnership in this regard and has a key advisory role to the IJB. The IJB is recognised as a community planning partner.

Key Issues:
The Council and the Health Board remain accountable for the functions delegated to the IJB and therefore must make sure that appropriate governance arrangements are in place for the IJB as set out in the Integration Scheme. The proposals in this report support the strategic planning function and broader commissioning role of the IJB for health and social care services and partnership working with other statutory agencies, the Third Sector, service users, their families/carers and the community. The key issues considered in preparing this report are with regard to the governance arrangements. The proposals are for a clear distinction in the roles of the different partners that will properly reflect the levels of authority and accountability for the partners in terms of health and social care services.

Implications :	
Service Users, Patients and Communities:	The IJB has a Participation and Engagement Strategy to ensure the views of service, users, patients and communities are heard and taken into account in developing services. Information in this regard will be available to SADP as appropriate. SADP through its members will ensure the best possible information is shared as appropriate to inform and support any recommendations to the IJB.
Human Resources and Organisational Development:	SADP supports multi-agency, multi-disciplinary working. This is reflected in the Substance Misuse Service Redesign implemented in April 2015. Work to support the Substance Misuse and Recovery Service (SMRS) hosted by the NHS is provided by the Human Resources (HR) and Organisational Development (OD) support arrangements in place for the IJB, which are described in the Integration Scheme[1].
Equality, Diversity and Human Rights:	Quality assurance on Equalities, Diversity and Human Rights is an integral part of the activities of the Council and the Health Board. The recommendations in this report do not require an Equalities Impact Assessment.
Legal:	The proposals in this report support the work of the Council, the Health Board and the IJB required under the terms of the Public Bodies (Joint Working) (Scotland) Act 2014, the associated Regulations and Guidance and Shetland's Integration Scheme.

[1] Shetland's Health and Social Care Partnership Integration Scheme 2015
http://www.shetland.gov.uk/Health_Social_Care_Integration/Integrationscheme.asp

Finance:	Any expenses and costs associated with the activities of the SADP are met from within existing budgets of the Council and the Health Board. The costs will be recorded and monitored to inform future budget setting processes.
Assets and Property:	There are no implications for major assets and property arising directly from this report. SADP continues to explore options for better accommodation for the SMRS team; this was identified as an issue in the service redesign project. Decisions of the Council and the Health Board would be required for any proposals in this regard as any costs would have to be met by the Council and/or the Health Board. All meetings of the SADP are held in either the premises of the Council or the Health Board and the costs are covered accordingly by the Council and the Health Board.
Environmental:	There are no environmental issues arising from this report.
Risk Management:	SADP has been active for many years supporting the Council, the Health Board and other community planning partners with plans for substance misuse services. There have been discussions over the years regarding the need for clarity in the roles and responsibilities of the members of SADP, particularly with regard to recommendations for commissioning services and conflicts of interest. More recently, with the implementation of the Public Bodies Act, it has become clear that the TOR should be revised to take account of the delegation of the substance misuse functions of the Council and the Health Board to the IJB. Failure to establish clarity in this regard could compromise the roles of the statutory agencies including the IJB leaving them open to challenge and criticism from auditors and inspection authorities.

Policy and Delegated Authority:	The requirement for a local Alcohol and Drugs Partnership is set out in statutory guidance to health boards. The remit and membership of SADP require decisions of the partner agencies including the Council and the Health Board. The functions of the Council and the Health Board with regard to substance misuse are delegated to the IJB under the terms of the Public Bodies Act, therefore this report is presented to the IJB to agree the revised TOR and seeks recommendations from the IJB to the Council and the Health Board in this regard.
Previously considered by:	The recommendations in this report including the revised TOR were presented to SADP on 15 June 2016. SADP members recommend that the revised TOR are adopted.

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	28 June 2016
Report Title:	Shetland Alcohol and Drugs Partnership (SADP) Governance and Terms of Reference
Report Number:	CRP-14-16-F
Author / Job Title:	Christine Ferguson, Director Corporate Services

1. Introduction

1.1 This report presents information regarding the governance arrangements for SADP.

1.2 The main focus is the need to make sure that the Terms of Reference (TOR) and membership of SADP is appropriate with regard to the planning and commissioning of health and social care services for substance misuse following the implementation of the Public Bodies (Joint Working) (Scotland) Act 2014 (the Public Bodies Act) and the creation of Shetland's Integration Joint Board (IJB).
The IJB assumed full responsibility for the functions delegated to it by the Council and the Health Board, including those with regard to substance misuse, on 20 November 2015.

1.3 The report presents revised TOR for SADP and asks the IJB to recommend the TOR for approval by Shetland Islands Council (the Council) and Shetland NHS Board (the Health Board). Other partner agencies will also need to consider and approve the revised TOR.

2. Governance Arrangements and SADP

Accountability and Delegated Authority

2.1 The Council and the Health Board both have statutory duties with regard to the provision of services in the community to meet the needs of people who are vulnerable due to the misuse of alcohol and drugs. The functions of the Council and the Health Board in this regard are delegated to the IJB under the terms of the Public Bodies Act [1].

[1] Ref Shetland's H&SCP Integration Scheme 2015;
http://www.shetland.gov.uk/Health_Social_Care_Integration/Integrationscheme.asp

2.2 The Council and the Health Board are required to work in partnership with community planning partners through a local Alcohol and Drugs Partnership (ADP). In Shetland, this is achieved through SADP. SADP brings together representatives of the Council, the Health Board, police and fire and rescue services to develop strategic direction and to jointly commission services to address the needs of people in the community who have issues arising from the misuse of alcohol and/or drugs. The current role and remit of SADP (attached at Appendix 1) is set out in the Strategic Plan for Shetland's Health and Social Care Partnership.

2.3 In July 2015, the Scottish Government issued "Updated Guidance for Alcohol and Drug Partnerships (ADPs) on Planning and Reporting Arrangements"[2]. The key principles on which the Guidance is based include:
"*to strengthen local partnership working and accountability;" and*
"*to support ADPs to improve accountability to their CPP (*Community Planning Partnership*)/Joint Integration Board and demonstrate their contribution to their local SOA (*Single Outcome Agreement now replaced by the Local Outcome Improvement Plan*)/health and social plans by supporting joint improvements and supporting flexibility*;"

2.4 The Guidance also states that, "*It is imperative that ADPs link into local decision-making and raise awareness of alcohol and drug issues to inform local priorities, ensuring Strategic and Delivery Plans for alcohol and drug outcomes are embedded within new Health and Social Care arrangements"*.

2.5 The functions of the Council and the Health Board with regard to substance misuse services are delegated to the IJB together with a budget allocation which is set against the service delivery priorities set out in the IJB's Strategic Plan. Any changes must be referred to the IJB for a decision and if the decisions mean there is a material change to the Strategic Plan or the budget allocation, then the IJB's decision must be referred to the Council and / or the Health Board as required by the Integration Scheme.

2.6 This means that although the Guidance states that the "*Scottish Government earmarked funding to ADPs [...] is a partnership resource and the full allocation must be directed to ADP level for decision-making*", SADP can only make decisions within the scope of the decisions and decision-making processes of each of the partner agencies and for the Council and the Health Board this is through the delegated authority of the IJB. This is clear in Annex A of the Guidance which outlines what each ADP should include in substance misuse delivery plans for 2015-18. This states that:
"*Plans should be agreed by all your partner organisations*";
"*It is important that you include details of how decisions are made on investment of available financial resources";* and
"Under the Public Bodies (Joint Working) (Scotland) Act 2014 your Plan should articulate your ADP's relationship with the [] IJB as well as your ADP's on-going relationship with your Community Planning Partnership".

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[2] Updated Guidance for Alcohol and Drug Partnerships (ADPs) on Planning and Reporting Arrangements, Scottish Government, July 2015
http://www.gov.scot/Topics/Health/Services/Alcohol/treatment/ADPPlanningandReportingGuidance-July2015

The proposals from SADP for 2016/17 as set out in the Strategic Plan for substance misuse were approved by the IJB on 4 February 2016. The Section has now been revised and the updated version is included in the Strategic Plan 2016-2019, which is the subject of a separate report on today's agenda.

2.7 The IJB's Chief Officer is a member of SADP and the post holder has delegated authority from the Council and the Health Board with regard to the management and operational delivery of services as directed by the IJB including health and social care services for substance misuse recovery. However, strategic plans, including the Substance Misuse Local Delivery Plan, must be approved by the IJB and by the Council and the Health Board as part of the approval of the IJB's Strategic Plan. The Council and the Health Board will allocate budgets to support the Substance Misuse Local Delivery Plan alongside other health and social care budget allocations for the functions delegated to the IJB. Further details on these arrangements are set out in the Integration Scheme.

2.8 Alcohol and drug misuse issues are a significant aspect of the work of the Community Safety and Resilience Board (CSRB) and of the Shetland Partnership (SP). SADP provides information and advice to these partnerships to inform their planning and activities. Neither the CSRB nor the SP is accountable for the statutory functions of the Council or the Health Board in this regard.

2.9 The levels of authority relevant to the commissioning of alcohol and drug services are summarised in the table below.

Partnership/ Agency	**General provisions**	**Specific arrangements for Substance Misuse functions**
Shetland Partnership (SP)	No collective authority. Decision making authority for each partner at the table depends on their individual schemes of delegation. The SP works collaboratively across partner agencies to develop a Local Outcomes Improvement Plan (LOIP), which is subject to approval by each partner.	For the Council and the Health Board, authority is delegated to the IJB. The representatives of the IJB on the SP do not have delegated authority from the IJB in this regard.
IJB	Delegated authority from the Council and the Health Board for the commissioning of alcohol and drug services under the terms of the Public	Management and operational delivery of health and social care services for alcohol and drug services is directed by the IJB through their Chief Officer, the Director of

	Bodies Act. Further details are available in the Integration Scheme.	Community Health and Social Care. The Chief Officer does not have delegated authority for the approval of policy, strategic plans or service redesign.
SADP	No collective authority. Decision making authority for each partner at the table depends on their individual schemes of delegation.	Delegated authority from the Council and the Health Board is restricted to that held by the IJB's Chief Officer for management and operational delivery of health and social care services.
CSRB	No collective authority. Decision making authority for each partner at the table depends on their individual schemes of delegation.	No delegated authority with regard to health and social care services.

Financial Governance

2.10 The Scottish Government budget allocation for ADPs is paid to local NHS Boards with the expectation that the local ADP will consider how the budget should be spent looking at all the partnership's resources and allocating funding in line with the priorities set out in the LDP. This has been the established practice in Shetland for many years. The Council and the Health Board have approved the LDP including the budget allocation. The process and detailed expenditure has been managed by the senior jointly appointed manager for health and social care. This is the role now undertaken by the IJB's Chief Officer.

2.11 Where services have been commissioned from third parties, primarily from Third Sector organisations, the contractual arrangements with the service provider have been through the Council using the Council's procurement processes with smaller projects supported through a grant offer. Where there have been issues with regard to the contract or SLA, it has fallen to the Council to address the issues. The Integration Scheme for the IJB states that where there are any claims as a result of decisions taken by the IJB with regard to the commissioning of services, the liabilities are borne 50:50 by the Council and the Health Board therefore, going forward, it will be important to make sure that any agreements reflect this commitment by the two Parties as set out in the Integration Scheme.
The Council agreed on 28 April 2016 that in future all purchasing arrangements with third sector organisations would be under the terms of a formal contract rather than an SLA so that service providers are under no illusion that the arrangement is legally binding.

Records Management and Data Sharing

2.12 The standard template for SLAs with providers of health and social care services includes a section on data sharing and a commitment from the provider to use the single shared assessment process With You For You and to share information with partner agencies. This can be difficult to achieve in practice where the service provider is unwilling to co-operate with the statutory agencies.
This issue will be explored further through the Data Sharing Partnership as part of the work planned to implement the Commissioning and Procurement Framework recently developed by the Health and Social Care Partnership Local Partnership Finance Team to see whether or not more robust arrangements can be established and included in the contractual arrangements with independent service providers.

Working in Multi-Agency, Multi-Disciplinary Teams

2.13 There are a number of areas within the integrated health and social care services where staff from the Council and the Health Board work together in multi-agency, multi-disciplinary teams. The policies and procedures that support these arrangements have been in place for many years dating back to the protocols established for the Scottish Government's Joint Future initiative. There were questions asked during the redesign of substance misuse recovery services regarding the possibility of including staff employed by third sector providers in the joint management arrangements, however, this was seen by some managers as not feasible. Therefore the protocols for joint management arrangements will be reviewed and updated so that Third Sector and other independent providers can work together with staff of the statutory agencies in multi-agency, multi-disciplinary teams. This will be of particular relevance to the IJB's plans for localities.

SADP Terms of Reference

2.14 The current Terms of Reference and membership of SADP is attached at Appendix 1. The membership includes elected members of the Council and up to 31 March 2016 included the Chair and Manager of CADSS as the main Third Sector provider of services for substance misuse.

2.15 The Executive Manager Governance and Law has undertaken a review of Council appointments to external organisations. SADP is not an external organisation as such and elected members sit on other partnerships and partnership groups including the Shetland Partnership, the IJB, the Joint Staff Forum and the Community Safety and Resilience Board. However, the representatives of the other statutory agencies on SADP are all executive officers of their respective organisations and there is a perception that elected members of the Council have greater authority on SADP than other members, which is misleading as individual elected members do not have delegated authority from the Council. Also, with the implementation of the Public Bodies Act, the functions of the Council in this regard are delegated to the IJB.
It is recommended that in future, the Council should be represented on SADP by executive officers of the Council rather than by elected members and specifically by the Director of Community Health and Social Care in their role as Chief Officer for the IJB.

2.16 There have been discussions at SADP on a number of occasions over the years regarding the issues and risks of having an external / Third Sector service provider at the commissioning table given the clear conflict of interest and the potential for challenge in terms of the allocation of funding and of service contracts to third parties.
It is recommended that no independent sector providers should be members of SADP going forward however service providers may be asked to attend meetings of SADP for example to report on performance.

3. Conclusions

3.1 The TOR for SADP should be updated to recognise the delegation of health and social care functions for substance misuse to the IJB and to provide greater clarity regarding the governance arrangements of the different partnership arrangements in place locally. A draft revised TOR for SADP is attached at Appendix 2.

3.2 The proposals in this report require approval by the Council and the Health Board.

Contact Details:
For further information please contact:
Christine Ferguson, Director of Corporate Services
christine.ferguson@shetland.gov.uk
16 June 2016

Appendices

Appendix 1: Current Terms of Reference for SADP

Appendix 2: DRAFT Revised Terms of Reference for SADP

Background Documents

H&SCI Integration Scheme
http://www.shetland.gov.uk/Health_Social_Care_Integration/Integrationscheme.asp

Strategic Plan
http://www.shetland.gov.uk/Health_Social_Care_Integration/StrategicPlan.asp

SADP Terms of Reference

- To plan, coordinate and stimulate local action on drug and alcohol misuse.

- To assess the level of drugs and alcohol misuse within Shetland Islands based on established data collection methods and from time to time, specific commissioned research.

- To determine the social and economic consequences upon individuals, families and communities and make arrangements for appropriate, innovative, flexible and challenging those services to meet those needs.

- To ensure effective consultation, specifically through the Drugs and Alcohol Forum, and that the views of interested parties are taken into account in the design of service delivery models.

- To ensure consultation and cooperation between partner organisations.

- To draw up appropriate strategies to tackle the social and economic consequences of substance misuse, drawing on best practice from national and international sources, and set that out in an annual Local Delivery Plan.

- To allocate financial and draw resources to meet the priority needs, as described in the Local Delivery Plan.

- To monitor the impact and effectiveness of the various service delivery models and consequences, through the performance management arrangements. This might involve challenging individual agencies, taking risk on new and innovative practice.

- To oversee communication methods on safe practices, harm reduction and harm minimisation.

- To oversee training programmes, methods and coverage to ensure individuals, families, communities, organisations and professional groups have access to all the information they need.

- To challenge local perceptions and challenge a genuine community led approach to tackling drug and alcohol misuse.

Links to Key Strategies

- Community Safety Strategic Assessment
- Community Health Care Partnership – Extended Local Partnership Agreement
- Community Justice Authority Corporate Plan
- Single Outcome Agreement
- Housing/Homelessness Strategy
- Integrated Children and Young People's Service Plan

Membership – Current

Simon Bokor-Ingram (Chair) – Community Health and Social Care, Shetland Islands Council/NHS Shetland
Lindsay Tulloch (Vice Chair) – Chief Inspector/Area Commander Police Scotland
Dr Sarah Taylor, Director of Public Heath – NHS Shetland
Amanda Souter, Chair of Shetland Alcohol and Drug Forum – Police Scotland
Graham Clark, Assistant District Officer – Highland and Islands Fire and Rescue Service
Helen Budge, Director of Children's Services – Shetland Islands Council
Anita Jamieson, Executive Manager Housing and Capital Projects – Shetland Islands Council
David Morgan, Executive Manager Mental Health – NHS Shetland
Juergen Kurtz, Manager Community Alcohol and Drugs Services Shetland (CADSS)
Jacqui Diamond, Chair of CADSS
Denise Morgan, Executive Manager Criminal Justice – SIC
Councillor/Elected Member, Shetland Islands Council (x2)
Duncan MacKenzie, Procurator Fiscal Service
Stephen Morgan, Executive Manager Adult Social Work – SIC

Updated Feb 2016

DRAFT

SHETLAND ALCOHOL & DRUGS PARTNERSHIP (SADP)

TERMS OF REFERENCE
Revised June 2016

1. Background

1.1 NHS Boards are required to establish and support a local Alcohol and Drugs Partnership (ADP) in each local authority area to support their Community Planning Partnership (CPP) in tackling the issues of alcohol and drugs misuse in the local community recognising that a multi-agency approach is needed to achieve the outcomes required.

1.2 The role of the ADP is to have an oversight of substance misuse issues and service delivery locally, to undertake strategic planning activities and to advise the partners.

1.3 In Shetland, SADP has fulfilled this role since 2009 bringing together representatives of Shetland NHS Board (the Health Board), Shetland Islands Council (the Council), Police Scotland, Highlands and Islands Fire and Rescue Service and the Procurator Fiscal Service.

1.4 In June 2015, Shetland's Health and Social Care Partnership Integration Joint Board (IJB) was formally constituted as a public body under the terms of the Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) and on 20 November 2015, the IJB approved its first Strategic Plan and assumed responsibility for the functions delegated to it under the terms of the Act. Under the terms of the Act, a wide range of the health and social care functions of the Council and the Health Board are delegated to the IJB. The delegated functions include alcohol and drugs. This means that responsibility and authority for all strategic planning and commissioning decisions with regard to alcohol and drugs services for the Council and the Health Board rests with the IJB.

2. REMIT OF SADP

2.1 To plan, co-ordinate and stimulate local action on drug and alcohol misuse.

2.2 To assess the level of drugs and alcohol misuse within the Shetland Islands based on established data collection methods and from time to time, specific commissioned research.

2.3 To determine the social and economic consequences for individuals, families and communities and make arrangements for appropriate, innovative, flexible services to meet their needs and to provide constructive challenge to service providers.

2.4 To facilitate effective consultation, specifically through the Drugs and Alcohol Forum and that the views of interested parties are taken into account as appropriate. This includes service users, their families/carers and independent sector service providers.

2.5 To facilitate consultation and collaboration between the statutory partner organisations.

2.6 To draw up appropriate strategies to tackle the social and economic consequences of substance misuse, drawing on best practice from national and international sources and set that out in an annual Substance Misuse Local Delivery Plan.

2.7 To recommend allocating the approved financial resources made available by the partners to meet the priorities as described in the Local Delivery Plan.

2.8 To monitor the impact and effectiveness of the various service delivery models and consequences through effective performance management arrangements. This may involve challenging individual agencies and promoting risk taking advocating new and innovative practice.

2.9 To oversee communication methods on safe practices, harm reduction and harm minimisation.

2.10 To oversee training programmes, methods and coverage to ensure individuals, families, carers, communities, organisations and professional groups have access to all the information they need.

2.11 To challenge local perceptions and promote a genuine community led approach to tackling drug and alcohol misuse.

2.12 To make recommendations to the statutory agencies for decisions as required.

2.13. To establish and maintain links with other relevant partnerships i.e. Child Protection/Adult Support and Protection Committees to improve safety, wellbeing and promote recovery.

3. COMPOSITION

SADP Membership

3.1 SADP membership comprises:

- Chief Officer of the IJB, Director of Community Health and Social Care
- Chief Inspector/ Area Commander Police Scotland
- Assistant District Officer, Highlands and Islands Fire and Rescue Service
- Head of Planning and Modernisation, NHS Shetland
- Alcohol and Drugs Development Officer, NHS Shetland
- Service Manager Mental Health, NHS Shetland
- Director of Children's Services, SIC
- Executive Manager Adult Social Work, SIC (representing Chief Social Work Officer)
- Team Leader Children and Families Social Work, SIC
- Executive Manager Housing, SIC
- Executive Manager Criminal Justice, SIC
- Procurator Fiscal Service (Observer)
- Public Health Principal, NHS Shetland
- Clinical Director, Mental Health NHS Shetland
- Team Leader, SMRS

3.2 Members of SADP will be able to nominate a substitute if they are unable to attend a meeting of SADP subject to the agreement of the Chair.

Chair and Vice-chair

3.3 A Chair and Vice-chair will be appointed by the members of SADP from among their number every two years.

3.4 Individual members of SADP may serve multiple terms as Chair / Vice-chair.

Lead Officer

3.5 The Lead Officer for SADP is the Alcohol and Drugs Development Officer.

3.6 The Lead Officer will support the Chair/Vice-chair arranging meetings, preparing agendas and making sure all papers are issued a week in advance of each meeting with late submissions accepted only with the agreement of the Chair/Vice-chair.

Records of SADP meetings

3.7 A minute will be taken at every meeting of SADP and approved at the next formal meeting of SADP.

3.8 An Action Tracker will be maintained and reviewed at every meeting of SADP.

3.9 The records will be subject to Freedom of Information Requests and the Lead Officer will arrange responses to any requests for information about SADP.

In attendance

3.10 Other representatives of the partner agencies, service providers and other stakeholders will be expected to attend meetings of SADP as required depending on the agenda and subject to the agreement of the Chair/Vice-chair.

3.11 Representatives of national agencies including the Scottish Government will be invited to attend depending on the agenda.

4. Frequency of Meetings

4.1 SADP will meet six weekly or as agreed by SADP.
The dates will be set a year in advance.

4.2 Additional meetings will be arranged as required following discussion with the Chair.

4.3 Requests for items to be included on the agenda should be made through the Lead Officer and their inclusion on agendas will be at the discretion of the Chair.

4. QUORUM

5.1 The quorum for a meeting will be 5 members including representatives of at least 2 of the partner agencies.
Substitutes will be allowed by agreement with the Chair/Vice-chair.

5.2 If neither the Chair nor Vice-chair is available for a particular meeting, SADP may appoint a chair for that meeting only from among those members present at the meeting.

5. RESOLUTION OF CONFLICT

5.1 The discussion of agenda items will be carried out with the aim of reaching consensus. Where consensus is not reached, the Chair will identify the area of disagreement and this will be noted in the minute.

5.2 Any areas of disagreement and any unresolved issues will be brought to the attention of the Shetland Partnership and individual partner agencies as appropriate through reports prepared by the Lead Officer in discussion with the Chair.

ENDS

Agenda Item

9

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board (IJB)
Date:	28 June 2016
Report Title:	IJB Audit Committee Appointments
Reference Number:	GL-31-16-F
Author / Job Title:	Jan Riise – Executive Manager – Governance and Law

Decisions / Action required:

1. To welcome Tom Morton as the newly appointed NHS non-executive Board Member of the IJB.
2. To appoint an NHS non-executive Board Member of the IJB to the IJB Audit Committee.
3. To appoint a Chair to the IJB Audit Committee.

High Level Summary:

Mr Massey's term of office on the IJB as a non-executive Member of the NHS Board recently came to an end, and his position on the IJB has been filled by Mr Tom Morton, recently appointed by the Scottish Government as a non-executive Member of the NHS Board.

The IJB are required to appoint to the vacancy for an NHS non-executive Board Member on the IJB Audit Committee, and subsequently appoint a new Chair of the IJB Audit Committee, all in accordance with its terms of reference [Appendix 1].

Corporate Priorities and Joint Working:

The IJB Audit Committee has a key role in ensuring the efficient and effective performance of Shetland's Health and Social Care Partnership in order to deliver the outcomes set out in the Integration Scheme.

The IJB as a public body must ensure that it operates in accordance with relevant legislation and the principles and codes that apply to all public bodies.
This includes a duty of Best Value and achieving appropriate standards of performance across all activities.

For the IJB, quality assurance activities must cover all the functions delegated to the IJB by the Shetland Islands Council (the Council) and Shetland NHS Board (the Health Board).

Key Issues:

The IJB must make sure that an appropriate assurance framework is established with regard to the functions delegated to the IJB by the Council and the Health Board.
The IJB Audit Committee is a key component of the IJB assurance framework.

Implications :	
Service Users, Patients and Communities:	The IJB Audit Committee performs an important performance monitoring role with regard to the efficient and effective performance of the IJB itself and its role in commissioning health and social care services. The IJB Audit Committee complements the work of professional advisers to the IJB and of the Clinical and Care Governance Committee ensuring that the best possible outcomes are achieved for service users, patients and the community.
Human Resources and Organisational Development:	It was agreed that the internal audit function for the IJB will be undertaken by the Council's Internal Audit Service and this is reflected in their current work programme. Support for the IJB Audit Committee will be provided by the IJB's Chief Officer and Chief Financial Officer and Corporate Services Support as required.
Equality, Diversity and Human Rights:	Quality assurance on Equalities, Diversity and Human Rights is an integral part of the activities of the Council and the Health Board and any performance issues for the functions delegated to the IJB will be reported to the IJB or the IJB Audit Committee as appropriate. The recommendations in this report do not require an Equalities Impact Assessment.
Legal:	The IJB is required to properly manage its financial affairs under the terms of the Public Bodies (Joint Working) (Scotland) Act 2014 (the Act), the associated Regulations and Guidance and Shetland's Integration Scheme. The Audit Committee is a key component in fulfilling this legal obligation.
Finance:	Any expenses and costs associated with the IJB Audit Committee including backfill for its members will be met from within existing budgets of the Council and the Health Board. The costs will be recorded and monitored to inform future budget setting processes.
Assets and Property:	There are no implications arising from this report.
Environmental:	There are no environmental issues arising from this report.
Risk Management:	The main risk associated with this report is failure to appoint a Chair could impact on the continuing effective administration of the IJB Audit Committee.

Policy and Delegated Authority:	Shetland's Integration Joint Board (IJB) Audit Committee was formally constituted on 25 August 2015. The IJB has the authority to appoint a Chair to the IJB Audit Committee as set out in this report and in the approved terms of reference.
Previously considered by:	This report has not been presented to any other formal meeting.

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board
Date:	28 June 2016
Report Title:	IJB Audit Committee Appointments
Reference Number:	GL-31-16-F
Author / Job Title:	Jan Riise – Executive Manager – Governance and Law

1. Introduction

1.1 This report seeks to fill an NHS non-executive Member vacancy on the IJB Audit Committee and seeks the appointment of a Chair to the IJB Audit Committee.

2. Background

2.1 The IJB Audit Committee was formally constituted on 25 August 2015 (Min Ref. 04/15) and Mr Keith Massey was appointed as Chair. Mr Massey highlighted, at that time that his current term of office on the IJB as a non-executive Member of the NHS Board would come to an end in June 2016, but advised that his successor would be eligible to replace him. Mr Massey's position on the IJB has been filled by Mr Tom Morton as a non-executive Member of the NHS Board on the IJB. The IJB are required to appoint to the vacancy for an NHS non-executive Board Member on the IJB Audit Committee, and subsequently appoint a new Chair of the IJB Audit Committee.

2.2 As set out in the Terms of Reference, attached as appendix 1, the Chair and Vice-Chair of the IJB Audit Committee will be voting members of the IJB appointed from amongst those members appointed to the IJB Audit Committee; one will be an elected member of the Council and the other will be a non-executive member of the Health Board. They may not also be either the Chair or Vice-Chair of the IJB.

2.3 The role of Chair and Vice-Chair will rotate every 3 years with the first rotation taking place in May 2017.

2.4 Mr Morton and Ms Waddington are eligible to be appointed as a Member of the IJB Audit Committee. The Chair will be appointed from one of the two NHS Non-executive Board Members on the IJB Audit Committee. However if appointed as a Member of the IJB Audit Committee Ms Waddington, as Vice-Chair of the IJB, would not be eligible for the role of IJB Audit Committee Chair.

3. Conclusions

3.1 The vacancy on the IJB Audit Committee requires to be filled. This will then allow a Chair to be appointed to the IJB Audit Committee. The IJB Audit Committee is key to ensuring that an effective assurance process is in place reporting to the IJB regarding the assessment of governance arrangements, risks and post integration performance results.

3.2 The appointment of a Chair will ensure that function of the IJB Audit Committee is maintained in line with Shetland's Integration Scheme and the Public Bodies (Joint Working) (Scotland) Act 2014 ("the Act").

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21 June 2016

Appendices

Appendix 1: IJB Audit Committee Terms of Reference

Background Documents

IJB Minute – 25 August 2015
http://www.shetland.gov.uk/coins/submissiondocuments.asp?submissionid=18312

Shetland Health and Social Care Partnership
Integration Joint Board
Audit Committee - Terms of Reference

1. INTRODUCTION

1.1 The Integration Joint Board (IJB) is required to properly manage its financial affairs. A key component to fulfilling this obligation would be to have an Audit Committee.

1.2 The IJB Audit Committee was established as a Standing Committee of the IJB on 25 August 2015.

2. PURPOSE OF THE IJB AUDIT COMMITTEE

The IJB Audit Committee will have a key role with regard to:

2.1 Ensuring sound governance arrangements are in place for the IJB; and

2.2 Ensuring the efficient and effective performance of Shetland's Health and Social Care Partnership in order to deliver the outcomes set out in the Integration Scheme.

3. CONSTITUTION OF THE IJB AUDIT COMMITTEE

Appointments

3.1 The IJB will make all appointments to the IJB Audit Committee including the appointment of the Chair and Vice-chair of the Committee.

Membership

3.2 The Committee will consist of four voting members of the IJB comprising two elected members of the Council and two non-executive members of the Health Board.

Chair and Vice-Chair

3.3 The Chair and Vice-Chair of the IJB Audit Committee will be voting members of the IJB appointed from amongst those members appointed to the IJB Audit Committee; one will be an elected member of the Council and the other will be a non-executive member of the Health Board. They may not also be either the Chair or Vice-Chair of the IJB.

3.4 The role of Chair and Vice-Chair will rotate every 3 years with the first rotation taking place in May 2017.

Quorum

3.5 In accordance with the IJB Standing Orders for meetings, two members of the Committee will constitute a quorum, being one elected member of the Council and one non-executive member of the Health Board.

Frequency of Meetings

3.6 The Committee will meet at least quarterly.

In Attendance

3.7 The Chief Officer, Chief Finance Officer and Chief Internal Auditor and other professional advisers or their nominated representatives will normally attend meetings. Other persons shall attend meetings at the discretion of the Chair.

3.8 The external auditor will be invited to attend meetings of the IJB Audit Committee.

Sub-groups

3.9 The Committee may at its discretion set up working groups for specific tasks. Membership of working groups will be open to anyone whom the IJB Audit Committee considers will be able to assist in the task assigned. The working groups will report their findings and any recommendations to the IJB Audit Committee.

4. POLICY AND DELEGATED AUTHORITY

4.1 The IJB Audit Committee is authorised to request reports and to make recommendations to the IJB on any matter which falls within its Terms of Reference.

5. REMIT

5.1 The IJB Audit Committee will review the overall internal control arrangements of the IJB and make recommendations to the IJB regarding signing of the Governance Statement and any other matters within its Terms of Reference.

5.2 Specific areas of responsibility include:

Performance Monitoring and Best Value

1. To ensure that the Chief Officer establishes and implements satisfactory arrangements for reviewing and appraising service performance against agreed objectives, levels and standards of service.
2. To consider reports on performance and to review progress against the national outcomes and the outcomes in the Strategic Plan.
3. To review and advise on Best Value and performance initiatives.

Audit

1. To review and recommend the annual Internal Audit Plan to the IJB.
2. To oversee and review progress on actions taken on audit recommendations and report to the IJB on these as appropriate.
3. To consider monitoring reports on the activity of Internal Audit.

4. To consider External Audit Plans and reports as appropriate; any matters arising from these and management actions identified in response.
5. To review risk management and insurance arrangements and receive regular risk management updates and reports.
6. To ensure compliance with IJB governance arrangements and strategies e.g. Risk Management Strategy, Participation and Engagement Strategy.
7. To be responsible for setting its own work programme including reviews in order to properly advise the IJB on matters covered by the IJB Audit Committee's Terms of Reference.

Final Accounts

1. To consider the annual financial accounts of the IJB and any related matters before submission to and approval by the IJB.

Standards

1. To promote the highest standards of conduct and professional behaviour by IJB members in line with The Ethical Standards in Public Life etc (Scotland) Act 2000;
2. To assist IJB Members in observing the relevant Codes of Conduct.

Ends.

Agenda Item

10

Shetland Islands Council

NHS Shetland

Meeting:	Integration Joint Board (IJB)
Date:	28 June 2016
Report Title:	Adoption of Ethical Code of Conduct for Shetland IJB
Reference Number:	GL-32-16-F
Author / Job Title:	Jan Riise – Standards Officer – Integration Joint Board

Decisions / Action required:

1. To formally adopt the Model scheme for devolved public bodies as the Code of Conduct for all Members of Shetland's IJB.

High Level Summary:

Each Integration Joint Board in Scotland is required to produce a Code of Conduct for its Members. The requirement for the code to be based on the Parliamentary approved Model Code of Conduct for Members of devolved public bodies, is met by simply adopting the Model Code, unaltered.

The training received by IJB Board members before the IJB was formally constituted was entirely based on the Model Code. Furthermore, the IJB's own standing orders indicate the intention that Members will be governed by the terms of the Model Code. However, no actual decision has formally adopted said code and the purpose of this report is to rectify that position.

Corporate Priorities and Joint Working:

It is a Corporate objective of the IJB to operate under excellent governance arrangements, ensuring that the IJB operates the highest standards of integrity and conduct in its operation and decision making, achieved by adoption of the very code approved by the Scottish Parliament for application by devolved bodies.

Key Issues:

Integration Joint Boards are "devolved public bodies" for the purposes of the Ethical Standards in Public Life etc. (Scotland) Act 2000. As such it is a requirement for this public body to adopt a Code of Conduct and the prescription is that it should be based on the Model Code of Conduct for Members of devolved public bodies. By accepting the Model Code in its entirety, the Shetland IJB will meet that requirement.

Implications :	
Service Users, Patients and Communities:	In the event that any member of the public is of the view that the Board itself is in breach of its requirements under the Ethical Standards legislation or that an individual member of the Board has failed to manage their individual conduct in line with the prescribed code, then the matter could form the basis of a complaint to the Standards Commission. In order for this statutory right to be available the Board needs to have formally adopted the code which will apply. The purpose of this report is to put those arrangements in place.
Human Resources and Organisational Development:	There are no human resources implications arising from this report.
Equality, Diversity and Human Rights:	The code will apply equally to all participants of the IJB. All members of the public will have the same right of access to the procedures available in the event that a breach is considered to have occurred.
Legal:	The legal considerations underpinning the need to adopt a code are addressed in this report and there are no additional legal implications to consider.
Finance:	The IJB has already established its register of interests and required all of its Members to accept appointment of office based on observance of the Model Code. So the Board's practice is already in place and a formal adoption of the attached Code of Conduct carries no additional financial consequences.
Assets and Property:	There are no assets and property implications arising from this report.
Environmental:	There are no environmental issues arising from this report.
Risk Management:	The main risk associated with this report is that relying on the reference in the IJB's standing orders to the application of the Model Code is not sufficient proof of the IJB approving a Code of Conduct for application in relation to its membership. A decision based on this report will remedy that situation.
Policy and Delegated Authority:	Shetland's IJB has not delegated the decision required by this report and therefore it is appropriate for the Board to approve the Code of Conduct which will underpin the Board's overall approach to good governance and managing excellent ethical standards.
Previously considered by:	This report has not been presented to any other formal meeting.

Shetland Islands Council

Meeting:	Integration Joint Board (IJB)
Date:	28 June 2016
Report Title:	Adoption of Ethical Code of Conduct for Shetland IJB
Reference Number:	GL-32-16-F
Author / Job Title:	Jan Riise – Standards Officer – Integration Joint Board

1. Introduction

1.1 As the Shetland IJB is a public body constituted by statute, it is deemed to be a devolved public body. All devolved public bodies are required to put in place a Code of Conduct based on the Model Code for Members of Devolved Public Bodies which has been formally approved by the Scottish Parliament.

1.2 The purpose of this report is to enable Members of the Shetland IJB to formally approve a Code of Conduct for their purposes.

2. Background

2.1 From the outset, and even before the IJB had been formally approved by the Scottish Minister by order of Parliament, induction training was being run here in Shetland which included significant elements focusing on good decision making and managing conflicts of interest and other elements of ethical standards in public life.

2.2 Subsequently and after the Board was formed one of its early decisions was approval of its own standing orders. In those documents there was also reference to the Board and its Members conducting their business in line with the Model Code of Conduct but the Board has not formally approved its own code.

3. Details

3.1 There is a requirement for the Board to accept a Code of Conduct and one based entirely on the Model Code is attached for Members to consider.

3.2 It is within the Board's authority simply to accept the Model Code as is although there is also the power to make amendments thereto and incorporate those within their decision for approval.

3.3 In discussion with other standards officers for IJBs, those who I have spoken to have indicated that their own IJB accepted the Code unaltered and in order for there to be widespread consistency, it is my recommendation that Shetland IJB does likewise.

3.4 Although Members of the IJB will also be subject to other Codes of Conduct, in the case of Councillors, the Councillors' Code of Conduct, in the case of employees of either NHS or SIC, employee Codes of Conduct, whilst those Codes also have to be adhered to, it is necessary for the IJB to have its own separate Code of Conduct. One benefit of approval the Model Code is that it is very much in parallel with wording and principles applied in the existing Councillors' Code of Conduct. This leads to continuity and consistency for the Members of the IJB who are also the identified decision makers.

4. Conclusions

4.1 It is incumbent on the Shetland IJB to approve a Code of Conduct and the Model Code, as set out in Appendix 1, is presented for amendment / approval.

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Appendices:

Appendix 1 - Draft Code of Conduct for Shetland IJB

Background Documents:

Model Code of Conduct for Members of Devolved Public Bodies
http://www.standardscommissionscotland.org.uk/uploads/files/14419755671441959 32700442087.pdf

Shetland Health and Social Care Partnership

Code of Conduct for Members of the Integration Joint Board

Code of Conduct for Members of the Integration Joint Board

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SECTION 1: INTRODUCTION TO THE CODE OF CONDUCT

1.1 The Scottish public has a high expectation of those who serve on the boards of public bodies and the way in which they should conduct themselves in undertaking their duties. You must meet those expectations by ensuring that your conduct is above reproach.

1.2 The Ethical Standards in Public Life etc. (Scotland) Act 2000, "the Act", provides for Codes of Conduct for local authority councillors and members of relevant public bodies; imposes on councils and relevant public bodies a duty to help their members to comply with the relevant code; and establishes a Standards Commission for Scotland, "The Standards Commission" to oversee the new framework and deal with alleged breaches of the codes.

1.3 In this Code of Conduct "the Integration Joint Board" shall mean the Shetland Islands Integration Joint Board, established in terms of the Public Bodies (Joint Working) (Integration Joint Board Establishment) (Scotland) Order 2015. The Integration Joint Board is a relevant public body for the purposes of the Act. This Code of Conduct has been adopted by the Integration Joint Board to assist Members of the Integration Joint Board to fulfil the requirements of the Act.

1.4 As a member of a public body, it is your responsibility to make sure that you are familiar with, and that your actions comply with, the provisions of this Code of Conduct.

Appointments to the Boards of Public Bodies

1.5 Public bodies in Scotland are required to deliver effective services to meet the needs of an increasingly diverse population. In addition, the Scottish Government's equality outcome on public appointments is to ensure that Ministerial appointments are more diverse than at present**.** In order to meet both of these aims, a board should ideally be drawn from varied backgrounds with a wide spectrum of characteristics, knowledge and experience. It is crucial to the success of public bodies that they attract the best people for the job and therefore it is essential that a board's appointments process should encourage as many suitable people to apply for positions and be free from unnecessary barriers. You should therefore be aware of the varied roles and functions of the public body on which you serve and of wider diversity and equality issues. You should also take steps to familiarise yourself with the appointment process for the Integration Joint Board.

1.6 You should also familiarise yourself with how the Integration Joint Board's policy operates in relation to succession planning, which should ensure public bodies have a strategy to make sure they have the staff in place with the skills, knowledge and experience necessary to fulfil their role economically, efficiently and effectively.

Guidance on the Code of Conduct

1.7 You must observe the rules of conduct contained in this Code. It is your personal responsibility to comply with these and review regularly, and at least annually, your personal circumstances with this in mind, particularly when your circumstances change. You must not at any time advocate or encourage any action contrary to the Code of Conduct.

1.8 The Code has been developed in line with the key principles listed in Section 2 and provides additional information on how the principles should be interpreted and applied in practice. The Standards Commission may also issue guidance. No Code can provide for all circumstances and if you are uncertain about how the rules apply, you should seek advice from the public body. You may also choose to consult your own legal advisers and, on detailed financial and commercial matters, seek advice from other relevant professionals.

1.9 You should familiarise yourself with the Scottish Government publication "On Board – a guide for board members of public bodies in Scotland". This publication will provide you with information to help you in your role as a member of a public body in Scotland and can be viewed on the Scottish Government website.

Enforcement

1.10 Part 2 of the Ethical Standards in Public Life etc. (Scotland) Act 2000 sets out the provisions for dealing with alleged breaches of this Code of Conduct and where appropriate the sanctions that shall be applied if the Standards Commission finds that there has been a breach of the Code. Those sanctions are outlined in **Annex A**.

SECTION 2: KEY PRINCIPLES OF THE CODE OF CONDUCT

2.1 The general principles upon which this Code is based should be used for guidance and interpretation only. These general principles are:

Duty

You have a duty to uphold the law and act in accordance with the law and the public trust placed in you. You have a duty to act in the interests of the Integration Joint Board and in accordance with the core functions and duties of that body.

Selflessness

You have a duty to take decisions solely in terms of public interest. You must not act in order to gain financial or other material benefit for yourself, family or friends.

Integrity

You must not place yourself under any financial, or other, obligation to any individual or organisation that might reasonably be thought to influence you in the performance of your duties.

Objectivity

You must make decisions solely on merit and in a way that is consistent with the functions of the Integration Joint Board when carrying out public business including making appointments, awarding contracts or recommending individuals for rewards and benefits.

Accountability and Stewardship

You are accountable for your decisions and actions to the public. You have a duty to consider issues on their merits, taking account of the views of others and must ensure that the Integration Joint Board uses its resources prudently and in accordance with the law.

Openness

You have a duty to be as open as possible about your decisions and actions, giving reasons for your decisions and restricting information only when the wider public interest clearly demands.

Honesty

You have a duty to act honestly. You must declare any private interests relating to your public duties and take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership

You have a duty to promote and support these principles by leadership and example, and to maintain and strengthen the public's trust and confidence in the integrity of the Integration Joint Board and its members in conducting public business.

Respect

You must respect fellow members of the Integration Joint Board and employees of the Board and its Constituent Parties and the role they play, treating them with courtesy at all times. Similarly you must respect members of the public when performing duties as a member of the Integration Joint Board.

2.2 You should apply the principles of this Code to your dealings with fellow members of the Integration Joint Board, its employees and other stakeholders. Similarly you should also observe the principles of this Code in dealings with the public when performing duties as a member of the Integration Joint Board.

SECTION 3: GENERAL CONDUCT

3.1 The rules of good conduct in this section must be observed in all situations where you act as a member of the Integration Joint Board.

Conduct at Meetings

3.2 You must respect the Chairperson, your colleagues and employees of the Integration Joint Board in meetings. You must comply with rulings from the chair in the conduct of the business of these meetings.

Relationship with Board Members and Employees of the Integration Joint Board and its Constituent Parties (including those employed by contractors providing services)

3.3 You will treat your fellow board members and any staff employed by the Integration Joint Board and its Constituent Parties with courtesy and respect. It is expected that fellow board members and employees will show you the same consideration in return. It is good practice for employers to provide examples of what is unacceptable behaviour in their organisation. Public bodies should promote a safe, healthy and fair working environment for all. As a board member you should be familiar with the policies of the Integration Joint Board and its Constituent Parties in relation to bullying and harassment in the workplace and also lead by exemplar behaviour.

Remuneration, Allowances and Expenses

3.4 You must comply with any rules of the Integration Joint Board regarding remuneration, allowances and expenses.

Gifts and Hospitality

3.5 You must not accept any offer by way of gift or hospitality which could give rise to real or substantive personal gain or a reasonable suspicion of influence on your part to show favour, or disadvantage, to any individual or organisation. You should also consider whether there may be any reasonable perception that any gift received by your spouse or cohabitee or by any company in which you have a controlling interest, or by a partnership of which you are a partner, can or would influence your judgement. The term “gift” includes benefits such as relief from indebtedness, loan concessions or provision of services at a cost below that generally charged to members of the public.

3.6 You must never ask for gifts or hospitality.

3.7 You are personally responsible for all decisions connected with the offer or acceptance of gifts or hospitality offered to you and for avoiding the risk of damage to public confidence in the Integration Joint Board. As a general guide, it is usually appropriate to refuse offers except:

(a) isolated gifts of a trivial character, the value of which must not exceed £50;
(b) normal hospitality associated with your duties and which would reasonably be regarded as appropriate; or
(c) gifts received on behalf of the public body.

3.8 You must not accept any offer of a gift or hospitality from any individual or organisation which stands to gain or benefit from a decision the Integration Joint Board may be involved in determining, or who is seeking to do business with your organisation, and which a person might reasonably consider could have a bearing on your judgement. If you are making a visit in your capacity as a member of the Integration Joint Board then, as a general rule, you should ensure that your body pays for the cost of the visit.

3.9 You must not accept repeated hospitality or repeated gifts from the same source.

3.10 Members of devolved public bodies should familiarise themselves with the terms of the Bribery Act 2010 which provides for offences of bribing another person and offences relating to being bribed.

Confidentiality Requirements

3.11 There may be times when you will be required to treat discussions, documents or other information relating to the work of the Integration Joint Board in a confidential manner. You will often receive information of a private nature which is not yet public, or which perhaps would not be intended to be public. You must always respect the confidential nature of such information and comply with the requirement to keep such information private.

3.12 It is unacceptable to disclose any information to which you have privileged access, for example derived from a confidential document, either orally or in writing. In the case of other documents and information, you are requested to exercise your judgement as to what should or should not be made available to outside bodies or individuals. In any event, such information should never be used for the purposes of personal or financial gain, or for political purposes or used in such a way as to bring the Integration Joint Board into disrepute.

Use of Public Body Facilities

3.13 Members of public bodies must not misuse facilities, equipment, stationery, telephony, computer, information technology equipment and services, or use them for party political or campaigning activities. Use of such equipment and services etc. must be in accordance with the public body's policy and rules on their usage. Care must also be exercised when using social media networks not to compromise your position as a member of the Integration Joint Board.

Appointment to Partner Organisations

3.14 You may be appointed, or nominated by the Integration Joint Board, as a member of another body or organisation. If so, you are bound by the rules of conduct of these organisations and should observe the rules of this Code in carrying out the duties of that body.

3.15 Members who become directors of companies as nominees of the Integration Joint Board will assume personal responsibilities under the Companies Acts. It

is possible that conflicts of interest can arise for such members between the company and the Integration Joint Board. It is your responsibility to take advice on your responsibilities to the Integration Joint Board and to the company. This will include questions of declarations of interest.

SECTION 4: REGISTRATION OF INTERESTS

4.1 The following paragraphs set out the kinds of interests, financial and otherwise which you have to register. These are called "Registerable Interests". You must, at all times, ensure that these interests are registered, when you are appointed and whenever your circumstances change in such a way as to require change or an addition to your entry in the Integration Joint Board's Register. It is your duty to ensure any changes in circumstances are reported within one month of them changing.

4.2 The Regulations[1] as amended describe the detail and timescale for registering interests. It is your personal responsibility to comply with these regulations and you should review regularly and at least once a year your personal circumstances. **Annex B** contains key definitions and explanatory notes to help you decide what is required when registering your interests under any particular category. The interests which require to be registered are those set out in the following paragraphs and relate to you. It is not necessary to register the interests of your spouse or cohabitee.

Category One: Remuneration

4.3 You have a Registerable Interest where you receive remuneration by virtue of being:

- employed;
- self-employed;
- the holder of an office;
- a director of an undertaking;
- a partner in a firm; or
- undertaking a trade, profession or vocation or any other work.

4.4 In relation to 4.3 above, the amount of remuneration does not require to be registered and remuneration received as a member does not have to be registered.

4.5 If a position is not remunerated it does not need to be registered under this category. However, unremunerated directorships may need to be registered under category two, "Related Undertakings".

4.6 If you receive any allowances in relation to membership of any organisation, the fact that you receive such an allowance must be registered.

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[1] SSI - The Ethical Standards in Public Life etc. (Scotland) Act 2000 (Register of Interests) Regulations 2003 Number 135, as amended.

4.7 When registering employment, you must give the name of the employer, the nature of its business, and the nature of the post held in the organisation.

4.8 When registering self-employment, you must provide the name and give details of the nature of the business. When registering an interest in a partnership, you must give the name of the partnership and the nature of its business.

4.9 Where you undertake a trade, profession or vocation, or any other work, the detail to be given is the nature of the work and its regularity. For example, if you write for a newspaper, you must give the name of the publication, and the frequency of articles for which you are paid.

4.10 When registering a directorship, it is necessary to provide the registered name of the undertaking in which the directorship is held and the nature of its business.

4.11 Registration of a pension is not required as this falls outside the scope of the category.

Category Two: Related Undertakings

4.12 You must register any directorships held which are themselves not remunerated but where the company (or other undertaking) in question is a subsidiary of, or a parent of, a company (or other undertaking) in which you hold a remunerated directorship.

4.13 You must register the name of the subsidiary or parent company or other undertaking and the nature of its business, and its relationship to the company or other undertaking in which you are a director and from which you receive remuneration.

4.14 The situations to which the above paragraphs apply are as follows:

- you are a director of a board of an undertaking and receive remuneration declared under category one – and
- you are a director of a parent or subsidiary undertaking but do not receive remuneration in that capacity.

Category Three: Contracts

4.15 You have a registerable interest where you (or a firm in which you are a partner, or an undertaking in which you are a director or in which you have shares of a value as described in paragraph 4.19 below) have made a contract with the Integration Joint Board or one of its Constituent Parties of which you are a member:

(i) under which goods or services are to be provided, or works are to be executed; and
(ii) which has not been fully discharged.

4.16 You must register a description of the contract, including its duration, but excluding the consideration.

Category Four: Houses, Land and Buildings

4.17 You have a registerable interest where you own or have any other right or interest in houses, land and buildings, which may be significant to, of relevance to, or bear upon, the work and operation of the Integration Joint Board or one of its Constituent Parties to which you are appointed.

4.18 The test to be applied when considering appropriateness of registration is to ask whether a member of the public acting reasonably might consider any interests in houses, land and buildings could potentially affect your responsibilities to the organisation to which you are appointed and to the public, or could influence your actions, speeches or decision making.

Category Five: Interest in Shares and Securities

4.19 You have a registerable interest where you have an interest in shares comprised in the share capital of a company or other body which may be significant to, of relevance to, or bear upon, the work and operation of (a) the body to which you are appointed and (b) the **nominal value** of the shares is:

(i) greater than 1% of the issued share capital of the company or other body; or
(ii) greater than £25,000.

Where you are required to register the interest, you should provide the registered name of the company in which you hold shares; the amount or value of the shares does not have to be registered.

Category Six: Gifts and Hospitality

4.20 You must register the details of any gifts or hospitality received within your current term of office. This record will be available for public inspection. It is not however necessary to record any gifts or hospitality as described in paragraph 3.7 (a) to (c) of this Code.

Category Seven: Non–Financial Interests

4.21 You may also have a registerable interest if you have non-financial interests which may be significant to, of relevance to, or bear upon, the work and operation of the Integration Joint Board. It is important that relevant interests such as membership or holding office in other public bodies, clubs, societies and organisations such as trades unions and voluntary organisations, are registered and described.

4.22 In the context of non-financial interests, the test to be applied when considering appropriateness of registration is to ask whether a member of the public might reasonably think that any non-financial interest could potentially affect your responsibilities to the Integration Joint Board and to the public, or could influence your actions, speeches or decision-making.

SECTION 5: DECLARATION OF INTERESTS

General

5.1 The key principles of this Code, especially those in relation to integrity, honesty and openness, are given further practical effect by the requirement for you to declare certain interests in proceedings of the Integration Joint Board. Together with the rules on registration of interests, this ensures transparency of your interests which might influence, or be thought to influence, your actions.

5.2 Public bodies inevitably have dealings with a wide variety of organisations and individuals and this Code indicates the circumstances in which a business or personal interest must be declared. Public confidence in the Integration Joint Board and its members depends on it being clearly understood that decisions are taken in the public interest and not for any other reason.

5.3 In considering whether to make a declaration in any proceedings, you must consider not only whether you will be influenced but whether anybody else would think that you might be influenced by the interest. You must, however, always comply with the objective test ("the objective test") which is whether a member of the public, with knowledge of the relevant facts, would reasonably regard the interest as so significant that it is likely to prejudice your discussion or decision making in your role as a member of the Integration Joint Board.

5.4 If you feel that, in the context of the matter being considered, your involvement is neither capable of being viewed as more significant than that of an ordinary member of the public, nor likely to be perceived by the public as wrong, you may continue to attend the meeting and participate in both discussion and voting. The relevant interest must however be declared. It is your responsibility to judge whether an interest is sufficiently relevant to particular proceedings to require a declaration and you are advised to err on the side of caution. If a board member is unsure as to whether a conflict of interest exits, they should seek advice from the Integration Joint Board's Chairperson.

5.5 As a member of the Integration Joint Board you might serve on other bodies. In relation to service on the boards and management committees of limited liability companies, public bodies, societies and other organisations, you must decide, in the particular circumstances surrounding any matter, whether to declare an interest. Only if you believe that, in the particular circumstances, the nature of the interest is so remote or without significance, should it not be declared. You must always remember the public interest points towards transparency and, in particular, a possible divergence of interest between the Integration Joint Board and another body. Keep particularly in mind the advice

in paragraph 3.15 of this Code about your legal responsibilities to any limited company of which you are a director.

Interests which Require Declaration

5.6 Interests which require to be declared, if known to you may be financial or non-financial. They may or may not cover interests which are registerable under the terms of this Code. Most of the interests to be declared will be your personal interests but, on occasion, you will have to consider whether the interests of other persons require you to make a declaration. The paragraphs which follow deal with (a) your financial interests (b) your nonfinancial interests and (c) the interests, financial and non-financial, of other persons.

5.7 You will also have other private and personal interests and may serve, or be associated with, bodies, societies and organisations as a result of your private and personal interests and not because of your role as a member of the Integration Joint Board. In the context of any particular matter you will need to decide whether to declare an interest. You should declare an interest unless you believe that, in the particular circumstances, the interest is too remote or without significance. In reaching a view on whether the objective test applies to the interest, you should consider whether your interest (whether taking the form of association or the holding of office) would be seen by a member of the public acting reasonably in a different light because it is the interest of a person who is a member of the Integration Joint Board as opposed to the interest of an ordinary member of the public.

Your Financial Interests

5.8 You must declare, if it is known to you, any financial interest (including any financial interest which is registerable under any of the categories prescribed in Section 4 of this Code). There is no need to declare an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test. You must withdraw from the meeting room until discussion of the relevant item where you have a declarable interest is concluded. There is no need to withdraw in the case of an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

Your Non-Financial Interests

5.9 You must declare, if it is known to you, any non-financial interest if:

(i) that interest has been registered under category seven (Non Financial Interests) of Section 4 of the Code; or

(ii) that interest would fall within the terms of the objective test.

There is no need to declare an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

You must withdraw from the meeting room until discussion of the relevant item where you have a declarable interest is concluded. There is no need to withdraw in the case of an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

The Financial Interests of Other Persons

5.10 The Code requires only your financial interests to be registered. You also, however, have to consider whether you should declare any financial interest of certain other persons. You must declare if it is known to you any financial interest of:-

(i) a spouse, a civil partner or a co-habitee;
(ii) a close relative, close friend or close associate;
(iii) an employer or a partner in a firm;
(iv) a body (or subsidiary or parent of a body) of which you are a remunerated member or director;
(v) a person from whom you have received a registerable gift or registerable hospitality;
(vi) a person from whom you have received registerable expenses.

There is no need to declare an interest if it is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

You must withdraw from the meeting room until discussion of and voting on the relevant item where you have a declarable interest is concluded. There is no need to withdraw in the case of an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

5.11 This Code does not attempt the task of defining “relative” or “friend” or “associate”. Not only is such a task fraught with difficulty but is also unlikely that such definitions would reflect the intention of this part of the Code. The key principle is the need for transparency in regard to any interest which might (regardless of the precise description of relationship) be objectively regarded by a member of the public, acting reasonably, as potentially affecting your responsibilities as a member of a public body and, as such, would be covered by the objective test.

The Non-Financial Interests of Other Persons

5.12 You must declare if it is known to you any non-financial interest of:-

(i) a spouse, a civil partner or a co-habitee;
(ii) a close relative, close friend or close associate;
(iii) an employer or a partner in a firm;
(iv) a body (or subsidiary or parent of a body) of which you are a remunerated member or director;
(v) a person from whom you have received a registerable gift or registerable hospitality;
(vi) a person from whom you have received registerable election expenses. There is no need to declare the interest if it is so remote or insignificant that it could not reasonably be taken to fall within the objective test. There is only a need to withdraw from the meeting if the interest is clear and substantial.

Making a Declaration

5.13 You must consider at the earliest stage possible whether you have an interest to declare in relation to any matter which is to be considered. You should consider whether agendas for meetings raise any issue of declaration of interest. Your declaration of interest must be made as soon as practicable at a meeting where that interest arises. If you do identify the need for a declaration of interest only when a particular matter is being discussed you must declare the interest as soon as you realise it is necessary.

5.14 The oral statement of declaration of interest should identify the item or items of business to which it relates. The statement should begin with the words “I declare an interest”. The statement must be sufficiently informative to enable those at the meeting to understand the nature of your interest but need not give a detailed description of the interest.

Frequent Declarations of Interest

5.15 Public confidence in a public body is damaged by perception that decisions taken by that body are substantially influenced by factors other than the public interest. If you would have to declare interests frequently at meetings in respect of your role as a board member you should not accept a role or appointment with that attendant consequence. If members are frequently declaring interests at meetings then they should consider whether they can carry out their role effectively and discuss with the Chairperson of the Integration Joint Board. Similarly, if any appointment or nomination to another body would give rise to objective concern because of your existing personal involvement or affiliations, you should not accept the appointment or nomination.

Dispensations

5.16 In some very limited circumstances dispensations can be granted by the Standards Commission in relation to the existence of financial and nonfinancial interests which would otherwise prohibit you from taking part and voting on matters coming before the Integration Joint Board and its committees.

5.17 Applications for dispensations will be considered by the Standards Commission and should be made as soon as possible in order to allow proper consideration of the application in advance of meetings where dispensation is sought. You should not take part in the consideration of the matter in question until the application has been granted.

SECTION 6: LOBBYING AND ACCESS TO MEMBERS OF PUBLIC BODIES

Introduction

6.1 In order for the Integration Joint Board to fulfil its commitment to being open and accessible, it needs to encourage participation by organisations and individuals in the decision-making process. Clearly however, the desire to involve the public and other interest groups in the decision-making process must take account of the need to ensure transparency and probity in the way in which the Integration Joint Board conducts its business.

6.2 You will need to be able to consider evidence and arguments advanced by a wide range of organisations and individuals in order to perform your duties effectively. Some of these organisations and individuals will make their views known directly to individual members. The rules in this Code set out how you should conduct yourself in your contacts with those who would seek to influence you. They are designed to encourage proper interaction between members of public bodies, those they represent and interest groups.

Rules and Guidance

6.3 You must not, in relation to contact with any person or organisation that lobbies do anything which contravenes this Code or any other relevant rule of the Integration Joint Board or any statutory provision.

6.4 You must not, in relation to contact with any person or organisation who lobbies, act in any way which could bring discredit upon the public body.

6.5 The public must be assured that no person or organisation will gain better access to or treatment by, you as a result of employing a company or individual to lobby on a fee basis on their behalf. You must not, therefore, offer or accord any preferential access or treatment to those lobbying on a fee basis on behalf of clients compared with that which you accord any other person or organisation who lobbies or approaches you. Nor should those lobbying on a

fee basis on behalf of clients be given to understand that preferential access or treatment, compared to that accorded to any other person or organisation, might be forthcoming from another member of the Integration Joint Board.

6.6 Before taking any action as a result of being lobbied, you should seek to satisfy yourself about the identity of the person or organisation that is lobbying and the motive for lobbying. You may choose to act in response to a person or organisation lobbying on a fee basis on behalf of clients but it is important that you know the basis on which you are being lobbied in order to ensure that any action taken in connection with the lobbyist complies with the standards set out in this Code.

6.7 You should not accept any paid work:-

(a) which would involve you lobbying on behalf of any person or organisation or any clients of a person or organisation.

(b) to provide services as a strategist, adviser or consultant, for example, advising on how to influence the Integration Joint Board and its members. This does not prohibit you from being remunerated for activity which may arise because of, or relate to, membership of the Integration Joint Board, such as journalism or broadcasting, or involvement in representative or presentational work, such as participation in delegations, conferences or other events.

6.8 If you have concerns about the approach or methods used by any person or organisation in their contacts with you, you must seek the guidance of the Integration Joint Board.

ANNEX A

SANCTIONS AVAILABLE TO THE STANDARDS COMMISSION FOR BREACH OF THE CODE

(a) Censure – the Commission may reprimand the member but otherwise take no action against them;

(b) Suspension – of the member for a maximum period of one year from attending one or more, but not all, of the following:

i) all meetings of the Integration Joint Board;
ii) all meetings of one or more committees or sub-committees of the Integration Joint Board;
(iii) all meetings of any other public body on which that member is a representative or nominee of the Integration Joint Board of which they are a member.

(c) Suspension – for a period not exceeding one year, of the member's entitlement to attend all of the meetings referred to in (b) above;

(d) Disqualification – removing the member from membership of the Integration Joint Board for a period of no more than five years.

Where a member has been suspended, the Standards Commission may direct that any remuneration or allowance received from membership of the Integration Joint Board be reduced, or not paid.

Where the Standards Commission disqualifies a member of the Integration Joint Board, it may go on to impose the following further sanctions:

(e) Where the member of the Integration Joint Board is also a councillor, the Standards Commission may disqualify that member (for a period of no more than five years) from being nominated for election as, or from being elected, a councillor. Disqualification of a councillor has the effect of disqualifying that member from the Integration Joint Board and terminating membership of any committee, sub-committee, joint committee, joint board or any other body on which that member sits as a representative of their local authority.

(f) Direct that the member be removed from membership, and disqualified in respect of membership, of any other devolved public body (provided the members' code applicable to that body is then in force) and may disqualify that person from office as the Water Industry Commissioner.

In some cases the Standards Commission do not have the legislative powers to deal with sanctions, for example if the respondent is an executive member of the board or appointed by the Queen. Sections 23 and 24 of the Ethical Standards in Public Life etc. (Scotland) Act 2000 refer.

Full details of the sanctions are set out in Section 19 of the Act.

ANNEX B

DEFINITIONS

"Chair" includes the Integration Joint Board's Chairperson or any person discharging similar functions under alternative decision making structures.

"Code" code of conduct for members of devolved public bodies

"Cohabitee" includes a person, whether of the opposite sex or not, who is living with you in a relationship similar to that of husband and wife.

"Group of companies" has the same meaning as "group" in section 262(1) of the Companies Act 1985. A "group", within s262 (1) of the Companies Act 1985, means a parent undertaking and its subsidiary undertakings.

"Parent Undertaking" is an undertaking in relation to another undertaking, a subsidiary undertaking, if a) it holds a majority of the rights in the undertaking; or b) it is a member of the undertaking and has the right to appoint or remove a majority of its board of directors; or c) it has the right to exercise a dominant influence over the undertaking (i) by virtue of provisions contained in the undertaking's memorandum or articles or (ii) by virtue of a control contract; or d) it is a councillor of the undertaking and controls alone, pursuant to an agreement with other shareholders or councillors, a majority of the rights in the undertaking**.**

"A person" means a single individual or legal person and includes a group of companies.

"Any person" includes individuals, incorporated and unincorporated bodies, trade unions, charities and voluntary organisations.

"**Public body"** means a devolved public body listed in Schedule 3 of the Ethical Standards in Public Life etc. (Scotland) Act 2000, as amended.

"Related Undertaking" is a parent or subsidiary company of a principal undertaking of which you are also a director. You will receive remuneration for the principal undertaking though you will not receive remuneration as director of the related undertaking.

"Remuneration" includes any salary, wage, share of profits, fee, expenses, other monetary benefit or benefit in kind. This would include, for example, the provision of a company car or travelling expenses by an employer.

"Spouse" does not include a former spouse or a spouse who is living separately and apart from you.

"Undertaking" means:
a) a body corporate or partnership; or

b) an unincorporated association carrying on a trade or business, with or without a view to a profit.

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